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Systemic Blastomycosis: Report of a Case

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Recently, we had the opportunity to observe a patient with pulmonary and cutaneous manifestations of North American blastomycosis, and to witness the response to therapy with stilbamidine. Prior to the introduction of stilbamidine in 1951, Martin and Smith[1] reported that 92 per cent of the patients with the generalized form of the disease died within two years, although the prognosis was relatively good if involvement was limited to the skin. The disease is encountered most frequently in the Chicago area and in Louisiana, Tennessee and North Carolina, but there has been an increase in the number of cases reported in other areas.[2-4] All physicians are aware that recognition of any disease increases proportionally with the rise in suspicion on the part of the doctor. This case is reported, therefore, as another reminder of a disease, rare in this area, which may cause cutaneous and/or visceral lesions.

Blastomycosis may be so slowly progressive that the physician is not impressed with its severity, or it may run a rapidly fatal course. The disease may begin with cutaneous, pulmonary, osteomyelitic or even genitourinary symptoms, and consequently should be of interest to practitioners in all branches of clinical medicine. Unfortunately, there is no accurate record of the incidence of this disease in Florida because reporting it is not required by the State Board of Health.

Before 1951 treatment of blastomycosis included a wide variety of measures.[5] Some were of value: (1) The antibiotics were mostly useful in controlling secondary bacterial infections. (2) Potassium iodide usually proved effective to some degree, but was not given immediately when the patient was hypersensitive to the organism as determined by skin test.[2] In such a case, the hypersensitivity was decreased artificially by administering gradually increasing doses of vaccine. (3) Surgery consisting of drainage of deep lesions was often desirable,[2] and, if the lesions were accessible and single, they were excised. (4) Roentgen therapy was useful in cutaneous lesions, particularly if combined with iodides and vaccines. Schoenbach, Miller, Ginsberg and Long[6] were the first group of investigators to use stilbamidine in the treatment of blastomycosis and described their results in 1951. Since then, there has been a reduction in the mortality rate in systemic blastomycosis.

Pharmacology of Stilbamidine

The standardization of the size of the dose, method of administration, and duration of treatment had been established for stilbamidine prior to its use in blastomycosis. An excellent review of the properties of the drug was published by Schoenbach and Greenspan[7] in 1948, and summarized by Smith[8] in 1953. The following data were obtained from the latter source.

The drug possesses several unique properties and, if used injudiciously, can cause either immediate or delayed complications. Stilbamidine deteriorates rapidly when exposed to light, and a 15 minute exposure to direct sunlight may reduce its therapeutic efficiency and at the same time produce a toxic by-product capable of fatal renal and hepatic damage. Another unusual property of stilbamidine, upon exposure to ultraviolet light, is the development of fluorescence which can be useful in chemical determinations. Stilbamidine promptly leaves the blood stream and is stored in the body, being excreted slowly over several weeks or months. Patients, therefore, should be protected not only during treatment, by covering infusion bottles with dark paper or towels, but also after treatment by avoiding exposure to direct sunlight for one to two months. Recently, 2-hy-

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droxystilbamidine has been introduced, which is much less affected by sunlight and is equally as effective as stilbamidine.[9] The drug is administered intravenously, usually in doses of 150 mg. dissolved in 500 ml. of 5 per cent glucose. Daily doses are given until a total dose of 3.5 to 4.6 Gm. is reached. Some advocate three courses of 10 days each, separated by rest periods of one to two weeks.

If the drug is administered too rapidly, circulatory collapse may occur, but usually no discomfort is noted if it is given slowly or diluted properly. A tendency toward development of thrombophlebitis has been recorded by some observers.[5] Late toxic manifestations are less easily controlled and consist of a neuropathy, curiously enough, involving the sensory division of the trigeminal nerve. The onset of this complication is delayed several months after cessation of treatment. There is no known treatment for this late sequela, and it usually disappears spontaneously after several months. It is believed to be related to exposure to sunlight since the incidence is lower in protected patients. Smith[8] reported another late complication, namely, the development of hepatic and renal damage several months after completion of therapy, but he pointed out that this has been avoided since the deleterious effect of sunlight was discovered.

Report of Case

The patient, a 56 year old white man, was admitted to Tampa Municipal Hospital on April 20, 1954. One year previously, he had noted the simultaneous onset of exertional dyspnea, a mild nonproductive cough, and a small wartlike growth on the right cheek. Prior to that time his health had been excellent. He was a native of West Virginia, and although he had lived in Indiana near Chicago for 18 years of his life, he had resided in Florida for the past 14 years.

Fig. 1. — Photograph of a cutaneous lesion of the right cheek in a patient with systemic blastomycosis.

During the year before admission to the hospital in 1954, he consulted several doctors and was treated for the most part as a cardiac patient because of the respiratory distress. Meanwhile, the facial lesion became enlarged and ulcerated. He was subsequently seen by one of us (W.W.W.), whose biopsy specimen of the right cheek showed double-contoured bodies compatible with blastomycosis. The lesion was a rounded, irregular, verrucous-edged, elevated crusting ulcer almost vermilion in color (fig. 1). Upon admission to the hospital, the patient was not in acute distress, but appeared chronically ill and slightly dyspneic. The remainder of the physical examination gave normal results, especially that of the cardiovascular system. No rales were heard over either lung field.

Fig. 2. — Roentgenogram of the chest of a patient with systemic blastomycosis prior to treatment.

Roentgen examination of the chest revealed a diffuse, bilateral, granular and nodular infiltration (fig. 2). Smears made from the skin lesions and sputum demonstrated Blastomyces dermatitidis, and this finding was confirmed by mycologic culture. Blood chemistry studies indicated hepatic and renal impairment as evidenced by abnormal retention of Bromsulphalein, elevation of thymol turbidity and increased blood urea nitrogen. During the first few days of observation, prior to starting treatment, a small lesion appeared on the right wrist at a site where the patient had inadvertently rubbed the skin lesion on the face.

Despite the abnormality in hepatic and renal function studies, we decided to treat the patient with stilbamidine because of the high mortality rate associated with systemic blastomycosis. In view of the known hepatotoxic effect of the drug, the initial dose was 10 mg. the first day, 25 mg. the second day, and a stepwise increase was continued until 150 mg. per day was reached. He was treated for 30 days and received a total of 4.2 Gm. By the twelfth day of treatment the lesion on the right wrist had completely disappeared, and there was diminution in the size of the facial lesion.

Since the patient was to receive daily fluids, we elected to insert an indwelling intravenous polyethylene catheter. After five days, however, we were forced to remove it because of the development of thrombophle-

bitis. Whether this condition was due to the drug or to the plastic tube is not known, but it proved to be mild and responded to conservative measures. No further complications during therapy were observed.

The patient improved slowly but progressively. There was a steady decline of the blood urea nitrogen level to normal. Curiously, there was a transient rise of the serum globulin during treatment. Improvement of the pulmonary lesions was slow, and definite roentgen evidence did not appear until completion of therapy (fig 3).

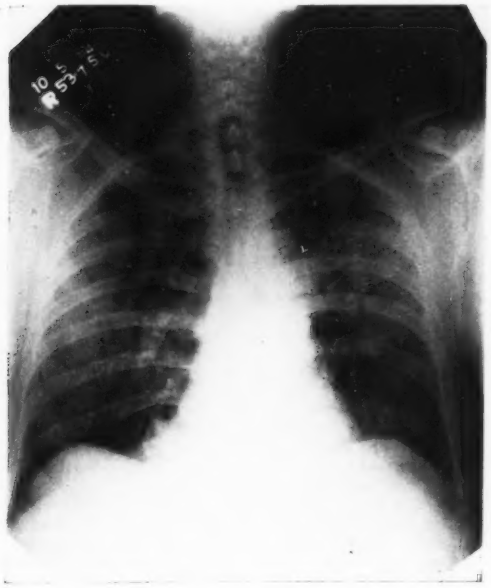

Fig. 3.— Roentgenogram of the chest of a patient with systemic blastomycosis at termination of treatment with stilbamidine.

There was, however, almost complete clearing of the skin lesion at the time of discharge from the hospital (fig. 4).

It is now nine months since completion of therapy, and the patient feels well except for diminution of light touch over the sensory portion of the trigeminal nerve on one side. This appeared as early as the third month after therapy was completed, but the condition has improved.

The patient received no therapy other than stilbamidine. Local roentgen therapy, potassium iodide, and vaccine therapy were purposely withheld to evaluate stilbamidine.

Fig. 4.— Photograph of a cutaneous lesion of the right cheek in a patient with systemic blastomycosis after termination of treatment with stilbamidine.

Conclusion

A case of systemic blastomycosis with excellent response to stilbamidine therapy is reported to illustrate the effectiveness of a new therapeutic agent in a highly fatal disease. Blastomycosis is a disease uncommon to this area, but important because its protean manifestations may make diagnosis difficult, and thereby delay the start of effective treatment.

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1955 Medical District Meetings

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October 12, District B, Gainesville
October 14, District A, Pensacola

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Hematuria During Treatment of Severe Hypertension with Hexamethonium Bromide and Pentolinium Tartrate

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Hematuria of varying degrees of severity is a common occurrence in patients with hypertension, regardless of etiology, and the recent development of potent remedies for this condition has made it necessary to watch for undesirable side effects. Gross hematuria occurred in one of my patients during treatment with hexamethonium bromide and pentolinium tartrate.

Report of Case

A white man, aged 37, first consulted me in February 1951, complaining of hypertension. There was a history of acute pyelonephritis of the right kidney in 1939, which followed complete obstruction of the ureter by a stone. The stone was removed, the obstruction was relieved, and the pus yielded Bacillus coli and Bacillus pyocyaneus. In October, 1949, he had chronic pyelonephritis. The urine showed 2 plus albumin, many leukocytes and some erythrocytes; a proteus organism was isolated from culture. Treatment for one week with streptomycin caused the urine culture to become negative. He was treated for a year in a Naval hospital with bed rest, sedation, a low salt diet and then a strict rice diet. The blood pressure dropped from 190/140 to a low of 150/90, but the improvement was temporary. At that time the kidney function tests showed 45 per cent elimination of phenolsulfonphthalein in two hours and a urine dilution and concentration range from 1.010 to 1.022; the blood nonprotein nitrogen was 31.2 mg. per hundred cubic centimeters of blood. The funduscopic examination showed arterial spasm. The heart was normal in size, and an electrocardiogram gave negative evidence.

When I first examined the patient on Feb. 26, 1951, his only complaint referable to hypertension was recurrent headache. At that time the blood pressure was 190/140. The eyegrounds showed spastic arterioles, but no exudate or edema. The urea clearance was 85 per cent; the urine contained 2 plus albumin, but leukocytes and erythrocytes were absent.

From then until November 1952 he was treated with simple hypotensive drugs and sedatives. He abstained from meat, coffee, tobacco and alcohol without reduction of blood pressure.

On Nov. 27, 1953, he submitted to right unilateral surgical sympathectomy. This included resection of the ganglia from the fifth thoracic to the third lumbar, inclusive; removal of the right greater and lesser splanchnic nerves and a portion of the right semilunar ganglion. At this operation, the right kidney was inspected; the pelvis showed no deformity and the adrenal gland was free of tumor. On Feb. 19, 1954, he submitted to left hemisympathectomy, which included the left sympathetic chain from the fourth thoracic to the first lumbar ganglion, inclusive, the greater and lesser splanchnic nerves and the entire left semilunar ganglion. One month after the second sympathectomy, the casual sitting blood pressure was 160/120. On May 2, the pressure was 200/140, and at this time there was recurrence of occipital headache.

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On May 21, about three months after the sympathectomy, I began to give him trial doses of hexamethonium bromide subcutaneously. There was little effect on sitting blood pressure until 15 mg. of the ion was given. This dose reduced the pressure from 210/140 to 160/110. A dose of 25 mg. produced a fall to 130/100. Thirty milligrams caused the sitting pressure to fall to 110/90 in six minutes. This change caused dizziness of such degree that the patient insisted on lying down. After five minutes in the recumbent position, the pressure was 190/140. These wide variations persisted for 90 minutes, and finally the pressure was fixed at 160/110 in the standing position. After 120 minutes, he walked to his car without complaints. An electrocardiogram, made after the sudden drop to 110/90, did not show S-T depressions or other evidence of coronary insufficiency.

On June 1, it was decided to have the patient's wife give him two injections of 25 mg. of the ion each day. He was not able to tolerate the morning dose because of dizziness in the upright position. He took one dose at 4:30 p.m. each day for 26 days, and then had gross hematuria while working as a clerk. After the first day of bleeding, he continued the medicine for two days and had hematuria each day. He eliminated the drug for two nights with immediate cessation of the hemorrhage. He took another dose, which was followed next day by bleeding. When the drug was finally discontinued, the hemorrhage stopped immediately without treatment. Cystoscopic examination and retrograde pyelograms failed to show any explanation for the bleeding. There was no reduction of the sitting blood pressure in my office at any time during this treatment.

On Feb. 23, 1955, he began to take pentolinium tartrate by mouth. The dosage varied from 60 to 120 mg. per day. The total quantity taken was 860 mg. On the twelfth day of treatment, he voided bloody urine in my office after his day's work as a clerk. The bleeding stopped without treatment within 24 hours. Before the drug was started, the afternoon urine showed 3 plus albumin, many casts, occasional leukocytes, but no erythrocytes. The phenolsulfonphthalein excretion was 68 per cent in two hours.

Comment

I want to emphasize the history of acute right unilateral pyelonephritis in this patient in 1939 at the age of 25 years. If this infection had been eradicated completely, he might never have had hypertension. In 1949 he had a blood pressure of 190/140, associated with chronic pyelonephritis. The diagnosis on these occasions was easy; but there are times when it is most difficult, such as when the urine presents no abnormalities except for the presence of the infecting organism on culture. Arteriolar nephrosclerosis[1] may result from pyelonephritis; but when this stage has been reached, the mechanism of its production alters neither therapy nor prognosis. Pathologic changes

in the kidney after long-standing pyelonephritis produce changes in the glomeruli and arterioles which would probably result in increased fragility of capillaries.

The action of both hexamethonium bromide and pentolinium tartrate is to block both sympathetic and parasympathetic nerve impulses at the autonomic ganglia. The hypotensive effects, according to Fries and his associates,[2] are accompanied by decrease in cardiac output and decrease of pressure in the right side of the heart. They suggested that these alterations are due to venous pooling and blockade of reflex vasoconstriction. They noted no change in peripheral vascular resistance of any significance.

The more frequent undesirable side effects of the drugs are orthostatic hypotension, constipation, paralytic ileus, hypotonicity of the urinary bladder, impotence in the male and intolerance of cold.[3] I will add gross hematuria to the list. Postural hypotension represents the most frequent and most troublesome effect and may prevent adequate dosage for good recumbent effect.

The hemodynamics dealing with the body as a whole and the kidney in particular are complicated and controversial. This patient's surgical sympathectomy had no lasting beneficial effect on blood pressure. This result is in keeping with the opinion of deTakats[4] that hypertensive patients with irreversible renal damage do not respond favorably to operation. The failure of operation is explained in various ways: It might be due to bridging of nerve gaps, or it might be caused by the assumption of functions of small nests of sympathetic ganglion cells in the anterior spinal nerve roots. It is also clear that sympathectomy in some manner often produces an increase in non-neurogenic or intrinsic vascular resistance.[5] The only fact that I have to explain the hemorrhage is the sudden broad variations in blood pressure that occurred after hexamethonium injection when the patient changed from the sitting to the lying position, and vice versa. It would appear that the changes in vascular dynamics are greater than the ability of a damaged kidney to adjust in patients whose autonomic ganglia are blocked with hexamethonium.

Several observers[2] studied renal alterations following administration of hexamethonium and concluded they are similar to those observed with hypotensive agents of all types and probably are secondary to sudden variations of arterial pressure, rather than to any specific action of individual drugs. Renal plasma flow decreased sharply at the onset of the hypotensive response, regardless of the drug used. This evidence of vasoconstriction after blockade suggests that other pressor mechanisms are operating. Among these might be acute renal ischemia, mediated through renin and its effector substance, hypertensin; and the more slowly acting pressor substance, pherentasin, which is the only pressor substance consistently found in hypertensive blood and not in normal blood.[8] It suggests also that the autonomy of renal vessels, as first observed by Smith and his associates,[6] might be the controlling mechanism.

The bleeding effect of hexamethonium is not limited to the kidneys. Mandelbaum, Brook and Mandelbaum[7] reported a case in which the patient had a massive hemorrhage from a quiescent duodenal ulcer without previous sympathectomy.

Summary

A case is reported in which gross hematuria occurred following subcutaneous injections of hexamethonium bromide and eight months later after oral treatment with pentolinium tartrate. The patient had previously been subjected to unsuccessful surgical sympathectomy. The renal bleeding stopped promptly without treatment after each drug was discontinued.

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Acute Renal Failure

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Acute renal failure is a term selected by Homer Smith to describe the abrupt cessation of renal function resulting in a self-limited period of azotemia terminating eventually in practically complete functional recovery or death. In general, this picture is best known as lower nephron nephrosis, a term coined by Lucke in his classic description of the syndrome in 1946. Microdissection of individual nephrons by Oliver has since shown that the term is a misnomer. The syndrome, however, will probably continue to be known as lower nephron nephrosis, at least until clarification of the pathogenesis enables a more precise definition.

During the London blitz of World War II, the occurrence of large numbers of crushing injuries terminating fatally one to two weeks later, not because of the injuries but because of uremia, stimulated Bywaters in England and later workers in this country to investigate the pathogenesis of this renal lesion.

Etiology

A wide variety of clinical states are known to produce the lower nephron syndrome. The most common precursors are shock and transfusions, singly or, as often occurs, in combination. Intravascular hemolysis brought about by incompatible transfusion, burns, intravenous distilled water, hyperthermia and blackwater fever, and myohemoglobinemia as occurs in crushing injuries, forms a large group in which pigment excretion seems to be the common denominator. Acute renal failure also may supervene during the course of severe liver damage, the so-called hepatorenal syndrome. Sulfonamide intoxication may cause oliguria or anuria due to a hypersensitivity reaction with renal ischemia and subsequent damage, or result in the precipitation of crystals which form mechanical blockade. Chemical poisons such as carbon tetrachloride have a nephrotoxic action. Severe infections, hemorrhagic fever and severe gastroenteritis, usually when associated with shock, are known to produce acute renal failure. Sensitivity reactions such as severe anaphylaxis may cause this syndrome.

The predominant pathologic feature is tubular necrosis and tubular regeneration or repair. The lesions are distinctly spotty in their distribution. Any portion of the nephron may be involved, and rupture of the basement membrane is a common finding. After the fourth or fifth day, evidence of repair is present with the laying down of a flat endothelial-like layer of cells. These later become cuboidal, and if the continuity of the nephron has not been disturbed, regeneration may be complete.

The mechanism underlying this tubular injury is not so clear. The relative importance of the role played by pigment excretion and that played by renal ischemia each has its advocates. Evidence to date is in favor of renal ischemia as the most important single precursor of this disease. Most of the clinical states leading to acute tubular necrosis are accompanied by shock. Lawson, Bradley and Cournaud clearly demonstrated the effect of shock on renal hemodynamics in man. Renal blood flow and glomerular filtration rate are reduced in practically every case when shock is present. This reduction is associated with a pronounced increase in renal resistance, indicative of renal vasoconstriction. These data indicate that during shock renal vasoconstriction occurs, shunting blood from the kidney to perfuse other parts of the body. Just how long one can tolerate renal ischemia before renal damage occurs is not known for man. Experimental data from animals would indicate that one and a half to three hours of complete renal ischemia is the critical limit; however, evidence seems to indicate that the human kidney is somewhat more susceptible.

The frequent association of intravascular hemolysis and pigment excretion with acute renal

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failure has led many observers to place an etiologic function on hematogenous cast formation in the renal tubules. Evidence to support this view is lacking. Experimentally in animals and man, large quantities of pigment have been tolerated without renal damage. Flink has shown in dogs that when enough pigment is given, uremia will result, but the amounts he used would be equivalent to hemolysis and over 1 liter of blood in man. Pigment excretion has proved injurious when associated with dehydration or shock, conditions which greatly lower the filtration rate. This would lead to reabsorption of a greater proportion of water in the proximal tubule and the delivery of a smaller volume of urine to the distal tubule. This reduction in urine flow would facilitate the precipitation of the pigment and cast formation. Cast formation, however, does not occur in the proximal tubule, but only in the ascending limb of Henle's loop, the distal convoluted tubule and collecting tubules. It would seem, then, that cast formation plays a secondary role in the production of lower nephron nephrosis, being due in part to the reduced filtration rate which accompanies renal ischemia. Those who would disregard the importance of casts, however, should heed the words of Oliver, who pointed out a fact that every plumber knows, that water cannot flow through plugged pipes.

Clinical Picture

The clinical picture of lower nephron nephrosis is that of acute renal failure with progressive azotemia. Within a few hours after the precipitating cause, severe oliguria is observed. While this is characteristic and is usually the basis of an early diagnosis, it is not always present. We have seen patients who maintained an output of 1 to 2 liters a day throughout the duration of the lower nephron nephrosis. This observation also has been made by John Merrill and his group in Boston and Arthur J. Merrill of Atlanta. Characteristically, though, the urinary output falls to less than 400 cc. a day for a variable period up to 23 days with the average around 10 to 12 days. We should like also to emphasize the fact that if anuria exists, that is, no output at all, one should question the diagnosis of lower nephron nephrosis since it is usually not associated with persistent anuria. At the onset, the urine is frequently dark and bloody. It contains albumin, casts, and numerous red and white blood cells. The specific gravity is low, usually 1.010, and it is acid. Examination of the blood at this stage is apt to reveal nothing unusual unless there has been intravascular hemolysis. The patient is suffering more from the primary disease at this point, and no characteristic symptoms are observed, although vomiting is frequently present.

During the oliguric phase, there is a steady daily rise in the nonprotein nitrogen or blood urea nitrogen. Along with the nitrogen retention, sulfates and phosphates are retained, and an acidosis supervenes with a reduction in the serum bicarbonate. For reasons not completely understood, there is a rapidly developing anemia with hemoglobin dropping to 7 or 8 Gm. in many cases. Attempts to correct this anemia by transfusion have not been successful, and since transfusion has frequently led to fatal pulmonary edema, it is contraindicated unless the patient is actively bleeding. If the patient is not overhydrated, he will be mentally clear at this stage. If too much fluid is given, he will be lethargic or frankly disoriented. Signs of an increasing blood volume will appear. Hypertension is most often due to hypervolemia. Edema occurs with overhydration, and in the past the most common cause of death in the oliguric phase has been pulmonary edema.

We saved the problem of potassium intoxication until last since this complication deserves the emphasis of special consideration. At present, the rise of potassium is not completely understood though two obvious factors are (1) tissue breakdown with release of potassium, while (2) the route of excretion via the kidneys is closed. It is impossible to predict the rate of rise or to know just when during the course of the disease the concentration will reach a toxic level. This uncertainty then predisposes to close and careful following of the patient, both by daily serum potassium determination and by electrocardiogram. Clinical manifestations of potassium intoxication are mainly related to the cardiovascular and neuromuscular systems. These include faint heart sounds of poor quality, a falling arterial pressure, bradycardia, arrhythmias and finally cardiac standstill. The patient will appear anxious, restless and apprehensive, and progression leads to stupor and convulsions. Reflexes are at first hyperactive, become hypoactive and then absent. Paresthesias are common, and weakness soon leads to paralysis. These, however, are terminal signs and should be avoided if possible. The electrocardiographic changes are characteristic.

Animal experimentation shows that in dogs the earliest of the electrocardiographic changes

is a tenting or peaking of the T waves. This is followed by a depression and shortening of the ST segment and a gradual merging of this segment with the upstroke of the T wave. P waves are lost, and the QRS is spread. There is a decline in the height of the R waves with a deepening of the S waves. Further progression leads to disruption of the complexes and a sine wave type of tracing and eventually asystole.

Therapy

Management of patients with lower nephron nephrosis has evolved considerably since World War II when many of the patients with this disease were drowned by excessive fluids. Renal denervation and renal decapsulation had their heyday and have been discarded along with other ineffective methods.

Present day therapy is based upon the regulation of fluid balance and nutrition in order that the patient may survive until the kidneys are able to reconstitute themselves.

The average person at basal conditions will lose approximately 700 cc. of fluid by way of the skin and lungs, and this loss will constitute the bulk of the insensible fluid loss with maybe an additional 50 cc. a day with normal bowel actions. Thus the daily fluid requirement would be 700 to 750 cc. daily with additional allowances given only to replace urinary output and actual losses by gastric suction, diarrhea, fistulas, excessive sweating, and other means, should any of these be present. If the patient is vomiting, this fluid should be given intravenously as 20 to 25 per cent glucose in distilled water in an attempt to maintain nutrition. The glucose should be covered by regular insulin, 1/2 unit per gram, in an attempt to maintain serum potassium at normal or near normal levels. If the patient is not nauseated or vomiting, one may use fat and carbohydrate mixtures by mouth or tube. By reducing protein breakdown, one reduces urea formation as well as sulfates, phosphates, and potassium released by its catabolism.

No salt is given except to replace losses which may occur when gastrointestinal secretions are being lost. The serum sodium may drop to quite low levels. It is believed that this drop is usually due for the most part to hemodilution and the serum sodium can best be raised by fluid restriction rather than the administration of a sodium salt.

Toxic substances such as protein, potassium-containing substances such as fruit juice, magnesium and acid salts should be rigorously avoided.

Materials ordinarily excreted by the kidney, such as the antibiotics streptomycin, Aureomycin and others, should be used in much smaller doses.

Vitamin supplements are given daily.

Usually no attempt is made to correct the acidosis that nearly always occurs, since the administration of sodium bicarbonate is hazardous and the value of such a procedure has not been evident.

As pointed out earlier, the oliguric phase is variable, but averages 10 to 12 days. It is amazing but nevertheless true, that of the patients dying with lower nephron nephrosis, 25 per cent do so in the postoliguric or diuretic phase. This should emphasize the importance of conservatism and continued close following of the patient through this phase. As the diuretic phase is ushered in, the urinary output increases by 200 to 300 cc. a day at first and then more rapidly, so that soon the output may reach several liters a day. It is important to realize that renal function is still impaired at this stage as evidenced by the fact that most patients will continue to have a rising nonprotein nitrogen and blood urea nitrogen despite adequate urinary volume. The amount of salt which this urine contains will vary and must be carefully followed so that replacement can be intelligently pursued. Potassium and/or calcium depletion may occur and should be watched for. As acidosis is corrected, a lowered serum calcium may precipitate tetany.

By following such a program, most patients can be carried through seven to 14 days of renal shutdown.

In some patients, however, dangerous serum potassium levels will begin to develop despite glucose and insulin as recommended earlier. Potassium-removing resins should be used, and if ineffective, then these patients are candidates for a more dramatic form of therapy, namely, artificial dialysis. Gastrointestinal lavage and peritoneal lavage have been used with good results in some cases, but there are several disadvantages to each, and the mechanical or artificial kidney is by far the safest and most effective means of treatment. In general, artificial dialysis is indicated when serum potassium reaches 7 to 8 milliequivalents per liter and actually many times before these levels are attained. That is when the patient has clinical or electrocardiographic evidence of potassium intoxication regardless of the blood level. Then, too, the serum sodium would

be important, for a serum potassium of 7.0 milliequivalents would be less dangerous with a sodium level of 140 milliequivalents than with one of 120 milliequivalents. Another factor which would influence one in deciding upon dialysis would be the urinary output. If it appears that the output would reach or exceed 500 cc. a day within another 24 hours, one might temporize with an otherwise dialyzable patient. Dialysis is never indicated for uremia as such.

Conclusion

The historical, pathogenic and clinical aspects of acute renal failure are reviewed, and a conservative form of management is outlined. It is emphasized that good clinical judgment, based on experience and a thorough understanding of the disease, is imperative in the management of acute renal failure.

12 East Sturtevant Avenue.

Discussion

Dr. William J. Dean, St. Petersburg: I certainly enjoyed Dr. Freeman's paper. The subject is most interesting today since the concept of treatment of acute renal shut-down is somewhat different than it might have been a few years ago. Dr. Freeman covered the subject rather completely. I shall emphasize a few points that he made, placing most of the emphasis on the cardiovascular system.

After oliguria begins, the main danger, or the most common complication, is congestive heart failure. Some of you may be raising an eyebrow about the use of the term congestive heart failure here. It really does not matter whether you use that term or not, but actually the patient with acute renal failure will have all of the symptoms that one usually associates with congestive failure. True, he may have no evidence of cardiac damage beforehand. The electrocardiogram will be normal, and all of the tests will be normal. If one were going to be a real purist, he should call it hypervolemia, I presume, but the patient still will have all of the signs and symptoms that one usually thinks of — the edema, the pulmonary edema, as Dr. Freeman mentioned, and all of the other symptoms one usually associates with congestive heart failure. I think early recognition is important because this is the time when one must remember to restrict the intake markedly, as has been pointed out.

Next, I shall say just a word concerning hyperkalemia versus potassium intoxication. They are the same, and yet maybe there is a difference in degree. The symptoms that Dr. Freeman mentioned referable to the cardiovascular system, such as pulse changes, irregular rhythm and blood pressure changes, all really are associated with potassium intoxication. Why even make this distinction? Usually, or let me say I hope it is usually, there is some warning, or one has some idea that there is a hyperkalemia or elevated potassium before the full blown signs and symptoms of potassium intoxication manifest themselves. Dr. Freeman pointed out, and I believe Dr. Merrill and some of his group in Boston first showed that the sodium level is most important. If there is hyponatremia, or low serum sodium and acidosis, the electrocardiographic changes, and the clinical changes as well, are apt to be more pronounced with the same serum potassium level. For this reason it is important to know the level of the serum sodium and the carbon dioxide combining power.

With regard to the electrocardiogram, Dr. Freeman showed a slide of a dog which certainly is characteristic. He also made the remark that as one is following patients with this disease, it is important to obtain an electrocardiogram and to determine serum potassium levels daily. He certainly is right. It is confusing at times if one does not realize that these two determinations may not seem to correlate. The electrocardiogram may be definitely showing the peaked T waves while the serum potassium may not be markedly elevated. It is not known how to explain this lack of correlation completely. One theory has been that the electrocardiogram in this case is reflecting the intracellular potassium. I am not sure whether this is right or not, but I think that it is important to use either one, if they do not agree. If the electrocardiogram shows pronounced signs of potassium intoxication, then that is important even though the serum level may not agree. On the other hand, if there is what appears to be a normal electrocardiogram, but serum potassium levels are elevated, then there again this is important. If one has carried out all the steps that Dr. Freeman has mentioned and still is confronted with either one of these signs, then he should be thinking about the artificial kidney or some other dialysis measure.

Dr. Joseph H. St. John, Jacksonville: It would be superfluous for me to try to add to the excellent summary that already has been given, but I shall express a few personal thoughts. This problem of lower nephron nephrosis represents an important addition to the list of kidney diseases which just within the last 10 years have become subject to cure. Not only should the fields of microbiology, antibiotics, cancer detection and treatment, hormonal therapy, poliomyelitis with its great strides, and the prevention and treatment of heart disease share the limelight of progress in medicine, but the continuing study of the kidney and its afflictions has come a long way by the use of routine laboratory tests of the various electrolytes and the understanding of electrocardiographic changes in electrolyte disturbances.

The essence of treatment of acute renal failure is prevention of overtreatment and control and constant vigil of the patient on the physician's part. It is not a simple problem of seeing the patient once a day. It is a problem of living with the patient until the emergency is over, which may be 23 days or longer. The laboratory technician and the electrocardiographic technician should be called on not merely once a day but perhaps four, five or six times in a 24 hour period. The work is hard, the vigil constant, but the results most gratifying.

The scientific program for the 16th annual Medical District Meetings of the Florida Medical Association is published in this issue of The Journal on page 309.

Treatment of Varicose Veins of the Lower Extremity by Stripping

JAMES R. ANDERSON, M.D.
WEST PALM BEACH

It is the purpose of this paper to present a method of treatment of varicose veins of the lower extremity which I and others believe to be far superior to the formerly employed technic of ligation and injection. This newer technic has been termed vein stripping. The procedure will be described for those who are unable to see the motion picture.

Patients seek treatment of varicose veins for several reasons. These may be outlined as follows:

1. Cosmetic appearance
2. Symptoms of uncomplicated varicosities
   a. Heaviness
   b. Soreness
   c. Aching
   d. Cramps in legs
3. Complications
   a. Rupture
   b. Thrombosis and thrombophlebitis
   c. Stasis dermatitis and ulceration.

The cosmetic defects are well known to everyone and seldom bother men.

I cannot explain why some people with large veins do not complain of symptoms, while others have definite complaints of mild soreness along the veins, and heaviness and tiredness of the legs in the latter parts of a day. I never promise that vein surgery will stop night cramps, but I suggest that the wearing of adequate elastic support will give some indication of what can be expected of an operation. A 4 inch rubber elastic bandage (such as an Ace No. 8), applied from the toes to the knee, will eliminate much of the fulness, tiredness, and slight edema which occur from incompetent veins. This measure will help patients to decide whether or not they desire treatment if there is some difficulty in arriving at a decision in cases of early incompetency or minimal vein size or symptoms.

Complications of Varicose Veins

Complications of varicose veins include those in the vein itself and those of the leg. The veins are subject to (1) spontaneous thrombosis, and (2) rupture with bleeding. Chronic incompetence of veins leads to edema with stasis. Stasis leads to dermatitis and ulceration and/or pigmentation.

Stasis dermatitis with its itching, weeping skin surface is a most distressing condition. It is frequently treated for many months with salves and lotions with no thought being given to the underlying venous stasis and edema of the skin, which can be cured either by surgery, temporary adequate support, or bed rest with elevation.

Open sores or ulcers are observed frequently. I prefer that these be healed before vein stripping is attempted. They can always be healed, and usually without skin grafting, with proper elevation and dressings.

Previous deep thrombophlebitis is not a contraindication to treatment of superficial varicosities by stripping. If the patient gets some relief from wearing an elastic bandage, he will be helped by surgery. No special tests other than that are performed to test deep circulation. The varicosities which appear after deep phlebitis may be channels for collateral circulation at first, but these are incompetent superficial varicosities of no value when the femoral vein has been recanalized. Edema of the leg may still be present after vein stripping, and the patients in such cases may always require some elastic support, but it can usually be lighter than before stripping.

Evaluation of Veins Preoperatively

Evaluation of veins prior to stripping is made with the patient standing up. Special attention is paid in all cases to the lesser saphenous vein. This vein requires surgery in approximately 20 per cent of legs operated on, and its recognition is the most important feature of the preoperative examination. The vein courses under the thin enveloping fascia at the back of the knee before entering the popliteal vein. Its origin is at the lateral border of the foot and behind the lateral malleolus. Two methods help in its identification as an incompetent vein. The percussion-palpation maneuver transmits an impulse up or down the entire length of the vein. Because of valves

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it is rarely possible to send an impulse down a normal vein, but this is easily done in cases in which veins are incompetent. Another useful method is combined with tourniquet evaluation of the greater saphenous vein. The patient's leg is elevated and a tourniquet placed above the knee on the thigh. The patient stands up. The veins are inspected and palpated. If incompetency is only in the greater saphenous vein at the groin, no veins will be seen or palpated immediately, although the lesser saphenous vein will fill and be visible or palpable on the back of the calf or lateral ankle region during this tourniquet test. The test is then repeated; this time the examiner holds his thumb over the popliteal space, compressing the upper segment of the lesser saphenous vein as the patient stands. This procedure effectively prevents filling of the lesser saphenous vein and establishes a diagnosis.

Incompetent perforating branches of the greater saphenous vein are looked for during the tourniquet test. If any segment of the greater saphenous vein fills immediately when the patient stands with a tourniquet on his thigh, the incompetent perforating veins are present. Moving the tourniquet lower on successive repetitions of the test eventually will help to locate these communicating veins so that they may be marked for individual ligation at the time of surgery.

The afternoon or evening before operation, the patient's legs are inspected and palpated. Tourniquets are used when necessary to locate perforating veins. The incompetent veins are marked by a scratch on the skin of the foot below the internal malleolus and at the knee so that incision may be made directly over the vein.

The operation is usually performed with the patient under general anesthesia. The patient's legs are prepared by washing with soap and water and the application of ether, alcohol, and one of the mercurial or other suitable skin antiseptics. The toes are covered with a rubber glove. When the operation on the greater saphenous vein is performed, Pentothal Sodium, nitrous oxide and oxygen are the anesthetic combination of choice for the entire procedure, and the patient lies supine.

Greater Saphenous Vein Operation

The operation for the greater saphenous vein begins with a dissection of the saphenofemoral junction at the groin in an ordinary fashion, with ligation and division of all branches widely. The saphenofemoral junction is doubly ligated flush with the femoral vein. Small branches entering the femoral vein in the vicinity of the junction are ligated and divided by choice. The distal end of the saphenous vein in the groin is clamped and not ligated.

The next incision is made on the foot near the ankle over the palpable saphenous vein. The saphenous vein at the foot is dissected free of its nerve and clamped and divided. The distal end is tied. The proximal end is held, and a hole is made near the clamp into the side of the vein large enough to introduce the tip of the stripper into the lumen. More often than not, the tip will pass from foot to groin without difficulty. Occasionally it will pass only to the knee because of tortuosity of veins. In the latter eventuality, another stripper is introduced at the groin and passed distally into the saphenous vein. This usually will meet the other stripper, and both small ends can be obtained through one incision. Customarily I make an incision on the posteromedial aspect of the knee and examine the saphenous vein in this location for branches before stripping. If branches are found, they are clamped and divided. These may be ligated, or held for an attempt at stripping later.

When the preceding steps have been completed, the vein is removed by pulling on the stripper. The large knob prevents the vein from turning inside out. It usually telescopes the vein on itself as it is pulled through the subcutaneous fat, and the entire vein may be removed through the other incision. If the vein appears with an intact branch, this is clamped and divided. Most branches tear off and retract. At this stage it is wise to apply pressure for two or three minutes with a folded towel over the vein channel and to elevate the feet 10 or 12 inches. A special hinged ratchet board, under the mattress of the operating table, can be used for this, or the table may be placed in Trendelenburg position. Bleeding usually is minimal. If bleeding is excessive, it may be necessary to pack gauze into the channel temporarily, or even to open the channel for ligation of a branch, but this procedure is rarely required. Clots should be milked from the channels before wound closure.

Large branches and accessory saphenous veins are either avulsed with forceps after blunt subcutaneous dissection, stripped out, or ligated for later injection. As many large varices as possible should be removed rather than left for injections.

Occasionally large masses of veins are dissected en bloc through incisions 4 or more inches in length. Most patients with severe varicose veins do not object to scars in place of veins; they are told of the possibility of direct dissection before the operation.

Closure of wounds is performed with interrupted vertical mattress sutures of 3-0 silk in the skin. At the groin, subcutaneous 00 plain catgut is used, and the skin may be closed with a continuous suture in most instances.

When the patient returns to bed, the foot of the bed is elevated to 30 degrees. Fluids and diet are allowed as soon as the patient recovers from anesthesia. No walking is done the day of the operation, but the following morning all patients begin walking four minutes of each hour. They are dismissed from the hospital 48 hours after the operation. Most patients do not complain of pain, or, at most, they state there is a slight burning sensation at the groin.

After stripping has been performed, the patient visits the office for removal of sutures and closure by injections of any branches which remain filled with blood and palpable. Usually few injections are needed.

Lesser Saphenous Vein Operation

When the lesser saphenous vein is incompetent the operation is usually started with the patient lying prone. It is possible to perform the popliteal dissection with local infiltration anesthesia induced by a 2 per cent solution of procaine hydrochloride. The inhalation of nitrous oxide and oxygen is sufficient for amnesia for the brief period of the stripping of the lesser saphenous vein. In this way it is feasible to avoid the use of an intratracheal tube and still have the patient lying prone.

The skin incision for the lesser saphenous vein is made transversely in the middle of the popliteal space. When the subcutaneous fat has been divided down to the fascia, it is pushed proximally and distally so that the fascia may be incised at a right angle to the skin incision. Only after incision of the fascia is the lesser saphenous vein available for dissection. It is followed down between vessels and nerves by blunt dissection, ligated flush with the popliteal vein, and divided. Another incision is made behind the lateral malleolus and the lesser saphenous vein dissected, clamped and divided. The stripper may be passed from the foot to the knee in almost all cases, and the vein is easily stripped out. The fascia at the knee is closed with interrupted chromic 00 catgut, and the remainder in the usual manner.

Bandages are placed on each incision with elastoplast, and folded combination pads are laid along the course of the vein channels. The entire extremity is then wrapped lightly with No. 8 Ace Bandages, 4 inches in width.

Results

All patients with varicose veins operated on in this manner have been helped. All have been pleased with the result. There have been no unusual complications and no pulmonary emboli in my own patients.

421 Pan-A Building.

Discussion

DR. DONALD W. SMITH, Miami: I want to congratulate Dr. Anderson on this excellent film. I think it is technically beautiful and very clear. I am not one to discuss a paper on stripping because I do not do it routinely. I still believe that there are indications for high ligation and interruption of the incompetent perforators and then postoperative injection of areas of stasis failing to thrombose spontaneously. I do not agree with some that there is no place for injection and no place for stripping, and that the saphenous system should be dissected through multiple short transverse incisions. Stripping certainly has its place and should be used wisely.

The preoperative examination is most important in the success of surgery for varicose veins. When one is not stripping the veins, it is necessary to be accurate in locating these incompetent perforators. The patient must be examined after having been on his or her feet for some period of time so that these deep veins that are incompetent are incompetent when examined. This is not always the case when one examines a patient who has just gotten out of bed. I believe that when a high ligation is done, it should be complete. One should look for anomalous veins most carefully.

Stripping obviously eliminates the perforators. It also eliminates the large vascular bed frequently left as an annoying mass of thromboses after simple ligation. In many of my cases, I am unable to run the stripper through as nicely as Dr. Anderson has shown. I encounter masses of veins in the leg and around the medial aspect of the knee, which must be dissected. Stripping saves considerable time in their removal although bleeding may be plentiful. Tilting the table to elevate the legs and applications of pressure dressings will usually control the profuse bleeding although I prefer to ligate them individually if they can be located. Occasionally I have found some exceedingly long branches and have wondered if perhaps I were pulling some perforators out of the femoral vein, leaving damage to the deep circulation which might result in deep venous thrombosis and thus might explain the occasional case of postoperative edema.

I think it is definite that the pendulum has swung back to stripping. Twenty years ago surgeons were doing some stripping, and now we are back to it again but with a more rational approach, by combining a careful examination with stripping and dissection.

DR. JOHN J. FARRELL, Miami: I should like to congratulate Dr. Anderson on a beautiful presentation. I agree with him that stripping is probably the most definitive procedure that we have. I do not think that you can categorize patients with varicose veins, and along with Dr. Smith I think there are some in whom you cannot limit treatment to high ligation and multiple liga-

tions; you have to resort to stripping along with ligation. At times in stripping, to answer one statement that Dr. Smith made, there are many of the long-standing varicose veins that you can set out to handle easily with inside stripping and then you still can get into trouble. In those instances use the old outside Mayo stripper, and that will take care of the tortuous veins.

With regard to postoperative edema, I believe that all patients subjected to stripping procedures should be made to wear Ace Bandages for at least a month, preferably six weeks, postoperatively, for by so doing they will bypass most of the edema. Actually the most important consideration on varicose veins really is not to allow veins to be of such long standing that stasis dermatitis, stasis eczema and ulcers occur. If more veins were treated earlier, the end result would be much better than at present, and for that reason we ought to take a much more vigorous attitude toward the treatment of varicose veins.

Trichomonal and Mycotic Vaginitis Controlled with Baculin and Amfrecin

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"The most vulgar denominate the discharge 'the whites'." Thus Clarke[1] wrote in 1814 concerning "the most frequent complaint to which women are liable" — the condition he and his contemporaries called fluor albus or fluor muliebris. In 1836 Donné reported to the French Academy of Sciences his discovery of a microscopic organism in purulent secretions from the male and female genital organs. This "infusorial" organism he named Trichomonas. His discovery attracted little attention until 1855 when Kolliker reported finding the organism in 50 per cent of the women he examined.

All patients examined for the causative factor of vaginitis should be scrutinized carefully for cervical lesions, which must be considered precancerous until disproved by biopsy. In a large percentage of cases of carcinoma of the cervix there is a history of vaginal infestations of long standing. It is axiomatic that cervicitis and cervical erosions must be corrected immediately regardless of the age of the patient.

Numerous authors have reported the ubiquitous nature of the trichomonad, not only in the vagina, cervix, vulva, urethra and even the bladder of the female, but also in the preputial sac, urethra, prostate, seminal vesicles and bladder of the male. It is now known that 80 per cent of vaginal inflammations and of leukorrhea are caused by Trichomonas.[2] Davis[3] found some type of discharge in one third of a group of 1,000 gynecologic patients.

From the Department of Obstetrics and Gynecology, Mercy Hospital, Miami.

*Amfre Drug Co., Inc., New York. Each Baculin Vaginal Tablet and each gram of Baculin Vaginal Powder contain diiodohydroxyquinoline 100 mg., phenylmercuric acetate 3 mg., sodium lauryl sulfate 3 mg., lactose 430 mg., dextrose 430 mg., aluminum potassium sulfate 14 mg., and papain 20 mg.

**Amfre Drug Co., Inc., New York. Each teaspoonful of Amfrecin douche powder contains sodium lauryl sulfate 12.5 mg., papain 50 mg., citric acid 0.8 Gm., actose 4.1 Gm., methyl salicylate 12.5 mg. and menthol 12.5 mg.

As the trichomonad is transferred by body to body contacts, it is commonly found in girls' orphanages, old ladies' homes, and among mothers and daughters who exchange articles of clothing. It is most frequently transmitted by sexual intercourse.

Diagnosis

The wide prevalence of trichomonal infestation makes it important to the general practitioner as well as to the gynecologist. It is therefore desirable that a simple and efficacious therapy be available and that the family doctor learn to diagnose the condition when he encounters a case of leukorrhea. Since the majority of cases of leukorrhea are caused by Trichomonas, he should suspect this cause and look for the organism under the microscope — either a stained or unstained specimen. Most of the cases of leukorrhea not due to Trichomonas are caused by the fungus Candida albicans, and the remainder by a score of species of organisms, including staphylococci, streptococci, pneumococci, micrococci, the Ducrey bacillus and the gonococcus.

The vaginal speculum should be inserted without lubricant, since acid jelly lubricants immobilize the trichomonad. With a cotton swab material is transferred from the fornices to a small quantity of Ringer's solution. The organism is easily identified by its flagella and undulating membrane. This method together with the smear stained with the conventional Papanicolaou stain will identify the trichomonad in practically every case.[4] It is rarely necessary to culture the organism for its identification, but it grows well in practically all nutrient mediums containing blood or serum.

Fortunately for the practitioner, now that

broad spectrum antivaginitis remedies are available, it is seldom necessary to determine the actual specific causative organism.

Symptoms

The discharge in trichomonal vaginitis is yellowish, foul in odor, frothy and bubbly. It is highly irritating to the vulva and the skin on the inner sides of the thighs. There is intense itching and burning of the vulva and the vagina. Small petechiae may be seen on the vaginal walls. The discharge from an infestation of the vagina by Candida is highly irritating to the vulva, but does not scald the inner aspects of the thighs as does that from Trichomonas. Many women harbor silent infestations of Trichomonas, and rarely does the organism give symptoms in the male.

Treatment

It often has been said that when there is a host of varied therapeutic regimens and products for a disease, none of them is satisfactory. Up to a few years ago this observation was true of Trichomonas vaginitis. Picric acid, arsenic, mercury and silver compounds, iodine, aniline dyes, sulfonamides, antibiotics, vaccines and hormones[5] all have been found wanting.

The difficulty with these older forms of treatment was that, although they might be effective trichomonacides in vitro, they did not suffice for the conditions under which the organism is found in the vagina — under a protective albuminous layer, in crypts, rugae and glandular ducts. No single substance could be effective since several objectives must be accomplished simultaneously.

I have yet to see a vaginal cream that is generally effective against infestations of Trichomonas and Candida. I now employ a most effective product, Baculin, which has been used in the 200 cases reported here. This product[6] contains, as its effective trichomonacide, a combination of the two most active compounds against Trichomonas and Candida, diiodohydroxyquinoline and phenylmercuric acetate, thus making it a veritable broad spectrum antivaginitic. The detergent, sodium lauryl sulfate, is added as a wetting agent to insure penetration of the antiseptics through the protein barrier and into the crypts, rugae and glandular ducts. Papain in the formula digests the mucus and liquefies the protein coating which protects the pathogenic organisms from the remedy.

The most effective measure against trichomonal infestation is maintenance of vaginal hydrogen ion concentration at approximately 4.0, the optimal acidity for a normal vaginal flora of Doederlein bacilli. This is accomplished by added aluminum potassium sulfate as a buffer. Lactose and dextrose further favor the nutrition of the normal flora, and the production of normal quantities of glycogen deposited in the normal vaginal epithelium.

Antibiotics have been found to be generally ineffective in the treatment of vaginitis.[7-9] In fact, they interfere with the normal vaginal bacterial flora and predispose to fungal predominance, largely Candida, leading to pruritus vulvae and ani.

Therapeutic Regimen

In the present series of 200 cases of vaginal discharge the following routine was used:

OFFICE ROUTINE. — After thoroughly flushing with an antiseptic solution and drying the vagina with cotton, and an electric hair dryer, I insufflate 1 ounce of Baculin powder through a speculum, making sure to cover the entire surfaces of the vagina, cervix and vulva, and ballooning the vagina to iron out the folds and rugae. This procedure invariably gives immediate relief from burning and pruritus.

HOME TREATMENT. — Instructions are then issued for treatment at home as follows:

Insert 2 Baculin tablets into the vagina each night and morning, stoppering the vagina with a pledget of cotton. Return for office treatment twice a week. Before and after intercourse, douche with the Amfrecin powder, 1 teaspoonful to 1 quart of warm water followed by insertion of 2 tablets into the vagina. Condoms must be employed until both husband and wife are free of organisms.

Alternating office and home treatments are continued through at least one menstrual period, preferably two or even three. During menstruation douching three or more times a day is recommended, with the usual insertion of 2 tablets and vaginal stopper afterwards.

Microscopic examination of vaginal secretions showed 98 per cent of the patients in this series to be free from Trichomonas and Candida after one month of this routine therapy. There were failures in 2 per cent due to lack of cooperation on the part of the patient or her husband. One husband refused to visit a urologist for treatment of a persistent trichomonal infestation of the prostate.

Enamel or stainless steel enema cans are to be preferred to the rubber douche bag. They can be drained dry to avoid development of mildew, molds, and bacterial contamination. The vaginal nozzle of the douche tube should be sterilized before each use. Formerly I advised the patient against forward use of toilet paper to avoid carrying Trichomonas from the bowel to the vulva and vagina; but recently it has been shown that Trichomonas intestinalis (or hominis) cannot grow in the vaginal environment. It is strongly recommended, but seldom heeded, that coitus be suspended during the entire course of treatment.

The most resistant cases in this series were those in which hysterectomy, or extensive cervical cauterization or conization had been performed, and those in which the patient was in the menopausal or postmenopausal period. A particularly persistent focus for reinfestation is the cervical stump.[10] All patients with reinfestation at this site required more careful and more intensive treatment. Reinfections probably occurred from the bladder, the cervical canal and Skene's ducts. The reinfections occurred most frequently during menstruation. Blood is apparently an ideal nutrient medium for Trichomonas.

Success with this therapy has encouraged its use not only in the usual forms of vaginitis with discharge, but also in senile vaginitis after excluding diabetes as its cause, in postpartum vaginal hygiene, and preoperatively and postoperatively in cervical and uterine surgery. This routine is effective in control of vaginal, vulvar and perineal irritation from malodorous puerperal discharges. Postpartum patients are instructed to use this therapy from the third week following delivery until their office check-up six weeks postpartum.

During pregnancy insufflation should be avoided, although Baculin vaginal tablets and douches at low pressure with Amfrecin may be employed. These treatments should be used during pregnancy for the minimum period required to control the vulvar and perineal irritation, the discharge, and the pruritus frequently so intense as to cause nervousness and insomnia. Pregnant patients need especially careful handling lest the condition become so severe that they require hospitalization.

Summary

Two hundred cases of vaginitis, largely trichomonal, were treated with Baculin, combining trichomonacides with supporting wetting agent, buffer, protein digestant and nutrient carbohydrates, and Amfrecin douches containing wetting agent, protein digestant, acid, carbohydrate and soothing, cooling antipruritics. In 98 per cent of these cases there was freedom from infestation after one month of treatment. This therapy was extended routinely to include use in preoperative and postoperative treatment in gynecologic surgery, in prepartum and postpartum vaginal hygiene, and in senile vaginitis with excellent results.

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513 duPont Building.

Approved Substitutes for One Per Cent Silver Nitrate For Prevention of Ophthalmia Neonatorum

The Florida State Board of Health has announced the approval of two preparations to be used by physicians as substitutes for 1 per cent silver nitrate for the prevention of ophthalmia neonatorum.

The substitutes are tetracycline ophthalmic ointment 1 per cent, or equivalent, and erythromycin ophthalmic ointment 1 per cent, or equivalent. Oxytetracycline (Terramycin) and chlortetracycline (Aureomycin) are included.

This action was taken pursuant to authority vested in the State Board of Health by Chapter 383.04 Florida Statutes, which provides that a 1 per cent solution of silver nitrate or other effective prophylactic approved by the State Board of Health be instilled into the eyes of every child at birth.

It should be emphasized that these substitutes for silver nitrate are approved for use only by physicians in hospitals. Midwives and those doing home deliveries are required to use 1 per cent silver nitrate.

The Ehlers-Danlos Syndrome Report of a Case

JACK W. FLEMING, M.D.
PENSACOLA

The Ehlers-Danlos syndrome[1,2] is an unusual clinical condition affecting the skin and skeletal systems. Features of the syndrome are:[3] (1) hyperelasticity of the skin, (2) fragility of the skin and blood vessels, (3) pseudotumors over bony prominences, related to skin fragility and trauma, and (4) hyperlaxity of the joints. Added to this tetrad more recently is (5) movable nodules beneath the skin of the extremities and buttocks.[4-6] Many congenital defects of varying types have been reported in association with the syndrome. Although the complete syndrome is reported to be rare, it is likely that cases with portions of the syndrome (formes frustes) occur more commonly than is generally appreciated. Also, the severity of the manifestations vary among different persons and among members of a family.[7]

Johnson and Falls,[7] in an excellent review and study of the clinical and genetic aspects of this condition, stressed the likelihood of the incomplete syndrome. They urged that internists be more aware of this possibility in patients with ecchymoses and hemorrhages, that surgeons detect this condition in patients with friable skin, and that orthopedists consider it more often in persons with unstable joints.

Clinical Features

HYPERELASTICITY AND HYPERLAXITY OF THE SKIN (DERMATOCHALASIS, LAXITAS CUTIS).—The skin has a characteristic feel similar to velvet over soft sponge rubber. Its consistency has been described as like the peeling of a baked apple,[1] like a rubber band,[8] and like the skin over the eyelids of a normal person.[7] The subcutaneous fat seems minimal, so that bony prominences are easily palpated.[3]

The skin may be tented or pulled away as much as 6 to 8 inches, and wrapped around a finger or in accordion folds.[3] When released, it returns to place without rugae or wrinkles. Elasticity may be limited to a few areas of the body, to one side of the body, or to the mucous membranes.[9]

FRIABILITY AND FRAGILITY OF THE SKIN (DERMATORRHEXIS, FRAGILITAS CUTIS).—Ronchese[10] stressed that fragility of the skin is usually one of the most prominent features of the syndrome. The patient may have repeated lacerations due to the slightest trauma. Because of the elasticity of the edges of the skin, small wounds may gape and cause difficult healing. Bleeding from the wounds is usually not a prominent feature because of this contractility of the edges of the wound; however, hematomas and ecchymoses are common because of fragility of the small vessels and supporting tissues. Blood coagulation studies have been normal, but there have been reports of excessive bleeding associated with trauma, tooth extractions, tonsillectomy and pregnancy.[7,8]

It should be noted that cutis laxa (in the India rubber man of the side show) differs from the usual case of the Ehlers-Danlos syndrome. In the former, the skin is tough, whereas fragility of the skin is a dominant feature in the Ehlers-Danlos syndrome.[11]

SCARS AND PSEUDOTUMORS. — The scars resulting from repeated trauma and unapproximated wounds are a characteristic and prominent feature of the syndrome. They are thin, wrinkled, papyraceous, and may resemble crinkled cigarette paper. They may be colorless or have bluish pink color; telangiectasia is often prominent. They are not adherent to the subcutaneous tissues and bulging or pedunculations of these scars result in the characteristic pseudotumors, which are found over the bony prominences, especially the knees and elbows.

HYPERLAXITY AND HYPEREXTENSIBILITY OF THE JOINTS (ARTHROCHALASIS, LAXITAS ARTICULARIS). — Severe forms of this characteristic may cause serious and disabling impairment of skeletal function, resulting in limitations in walking, standing, writing, and performing skilled movements. Subluxation and spontaneous dislocation of any of the joints are not uncommon. A person with this

feature of the syndrome may be able to place the arm behind the back and touch the ears with the fingers,[12] or touch the umbilicus with the heel of the foot.[13] The thumb is most commonly involved, and extension against the wrist may be easily possible.[7] Involvement of the joints of the feet may be manifested by third degree pes planus.[14] Less severe forms of this characteristic may cause no discomfort or disability and serve only as a source of amazement to those witnessing a performance.

Subcutaneous Nodules.—Spherules or small cystlike tumors are frequently palpable in the subcutaneous tissues of the extensor surfaces of the extremities and of the buttocks;[5,6] they probably result from trauma. These tumors range in size from that of a pea to a hazelnut.[7] They apparently are small, avascularized, budlike bodies of connective and adipose tissue which degenerate and become loose, movable nodules in the subcutaneous tissue. Calcification occurs in many of them, and this presents a characteristic roentgenologic picture: "In most instances, a central zone of relatively increased radiolucency is surrounded by a ring-like shadow of lime salt. Some of the nodules are faintly stippled and a few are entirely homogeneous, but these are in the minority."[6] These nodules are always superficial in location, whereas angiomatous phleboliths may be distributed through the deep tissues, may have concentric strata and vary more in size and regularity. Calcified larvae found in muscles as well as the other more common causes of soft tissue calcification are also usually not difficult to differentiate by roentgenogram.

Etiology

The etiology of Ehlers-Danlos syndrome is unknown. It may be familial or sporadic. There have been reports indicating that prematurity may be either a cause or an effect of this condition since in cases when only one child in a family manifested the syndrome, there was a history of prematurity in that affected person.[7]

This condition may be regarded as a congenital, constitutional and developmental mesenchymal dysplasia;[15] thus, the structures of ectodermal origin are affected only secondarily. Endocrine and metabolic disturbances have been suggested as etiologic agents, but there is little to support this view.

Genetics

Most reports indicate that this syndrome ordinarily is transmitted by a Mendelian dominant inheritance pattern; however, there are many reports of Ehlers-Danlos syndrome transmitted to affected offspring by normal parents. This transmission may be due to lack of penetrance of the gene (incomplete dominance), or the parents may actually have had a mild, undetectable form of it.[7] Other genetic explanations for sporadic occurrence of this condition in persons with normal parents are as follows, according to Johnson and Falls:[7] First, the affected person may receive an abnormal gene from both parents; thus this represents an autosomal recessive form of the disease. Second, there may be sex-linked transmission of the gene, and the condition may be present in females over several generations before a male is affected. Third, the case may represent a mutation in the germ plasm of one of the parents of the affected persons.

Pathology

Reports of biopsies of the skin show a wide variation in the findings. For the most part, increases in the number or size of the elastic fibers or abnormalities in their arrangement or appearance have been reported;[12,14] however, some authors have reported normal elastic tissue, diminution in the collagen of the corium, and abnormalities of the appearance of the collagenous fibers.[7]

The epidermis shows wrinkling due to the contractile, underlying corium. Atrophy and blunting of the rete pegs may be present. Blood vessels have been reported to be tortuous, thick-walled,[16] and thin-walled.[3]

The pseudotumors show proliferating blood vessels and connective tissue, and giant cells.[10,17] The subcutaneous nodules have dense collagenous fibrous tissue capsules which contain some intact fat cells, but mostly necrotic and calcified fat.[6] Giant cells also may be present in the nodules.

Treatment

There is no specific treatment for this syndrome. Attention should be given to protection of the patient from trauma. Pressure bandages over ecchymoses or hematomas may prevent the formation of pseudotumors.[16] Smith[18] reported that in one patient injuries to the skin were diminished considerably with gain in weight, thereby increasing the subcutaneous panniculus. Control of bleeding is usually not a problem since the edges of the skin retract. Special care in suturing or the use of mattress sutures, metal clips, or adhesive tape may be indicated in the repair of lacerations of the friable skin. If sutures are removed at the usual time, adhesive tape may be necessary

for reinforcement to the healing wound. Hyperextensible joints may necessitate stabilizing supports, braces, or orthopedic surgery.

Report of Case

A 22 year old private entered the United States Army Hospital at Camp Hanford, Washington because of an open wound on the anterior aspect of the right leg. Following a trivial injury 12 days prior to admission, he had sustained a laceration on the right leg. This laceration was sutured at that time, and after five days the sutures were removed. Two days later the edges of the wound retracted, leaving a gaping, superficial wound. Secondary infection then developed in this site.

Fig. 1. — Photograph showing crinkled, predunculated scars of both knees. The healing, unapproximated laceration on the anterior aspect of the right leg is apparent.

The patient had always noted that his skin was soft, easily bruised and easy to cut. When he was 7 years old, a doctor commented that his skin was "as soft and as thin as tissue paper." He did not bleed excessively, but had sustained numerous cuts and bruises over his lifetime. He had not had difficulty with unstable joints.

He had had occasional headaches as long as he could remember. Aching in the proximal joint of the right thumb had recurred since an injury four years prior to admission. An appendectomy at 11 years of age and injuries to his head and knees in an automobile accident five years later resulted in no complications.

His mother had "heart trouble." His father had chronic backache. Seven brothers and four sisters also were living and all were well. One brother had had a "stroke" at 23 years of age, but there were no residuals. There was no history of skin similar to the patient's or hyperlaxity of the joints in any member of the immediate family or distantly related relatives, to the patient's knowledge.

On physical examination, the blood pressure was 118 systolic and 78 diastolic. The patient weighed 160 pounds and was 70 inches tall. He was a quiet, pleasant man of average intelligence. The general physical examination gave essentially normal results with the exception of the following findings: The gag reflex was absent. An epicanthus was noted on the right eye. His hair was soft and fine. The face was full and "round," and he had a rosy, smooth complexion. The skin over his entire body, but to a lesser degree on his hands and feet, was extremely thin,

Fig. 2 — Photograph showing pseudotumor on the left elbow.

"rubbery," hyperextensible and contractile upon pinching palpation. Flat palpation of the skin gave the sensation of feeling extremely soft, sponge rubber. Pedunculated, violet-colored pseudotumors were noted over the knees and elbows. Their surfaces were smooth or crinkled like cigarette paper, and small telangiectases were apparent. The size of the scars and pseudotumors and their hyperextensibility are illustrated in figures 1, 2 and 3. Nonpedunculated similar large scars were noted over the abdomen at the site of appendectomy, the anterior tibial areas, and the left arm at the site of smallpox vaccination. Additional scars were located over the forehead, nose, hands, forearms and left calf. The infected laceration on the right leg measured about 3 cm. in length. There were moderate traumatic deformities of the metacarpophalangeal joints of both thumbs. Hyperextensibility was present in the joints of the distal phalanges of both thumbs and of the middle three toes, bilaterally. A hammer toe deformity was present in these toes, with contractions and shortening of the skin overlying the proximal phalanges.

Urinalysis, complete blood counts, platelet counts, and bleeding and clotting times were all normal. The nonprotein nitrogen, fasting blood sugar, and serum phosphorus were also within normal limits. A roentgenogram of the chest showed only an irregularity of the diaphragm on the right side, presumably the residual of old pleurisy. Roentgenograms of the hands and spine also gave normal

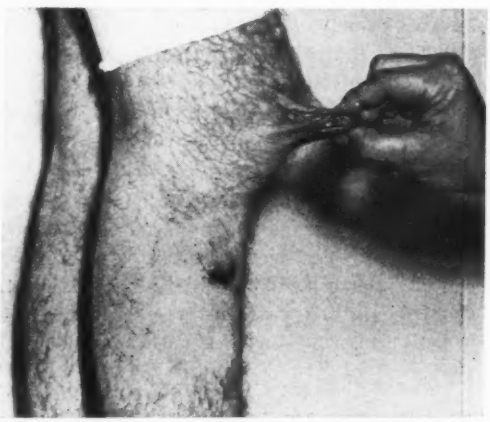

Fig. 3. — Photograph showing hyperextensibility of pseudotumor of the right knee.

results. Hemolytic streptococci were cultured from the site of the laceration.

Histopathologic examination of skin from the right thigh showed an apparent increase in numbers of elastic fibers when the specimen was stained with Verhoeff's stain for elastic tissue and compared with a microscopic section or control preparation of normal skin.

Discussion

The case reported here presented only moderate but definite changes of the skin and of a few toe joints, as compared with descriptions in other reports and in a case observed by me previously. The patient was not aware of features of this syndrome being present in other members of his family; however, his fragile, thin skin had been commented on since childhood. Although subcutaneous nodules were not demonstrated in this case, all of the other cardinal signs were present in a modified form.

After one has observed a patient with Ehlers-Danlos syndrome, it is not difficult to recognize the syndrome or its formes frustes. In normal persons the feel of the skin of the eyelids and frequently the skin along the inner aspects of the arms somewhat resembles that of the skin in patients with Ehlers-Danlos syndrome; however, the abnormal rubbery feeling and hyperelasticity are absent. Also, in normal persons, large scars produced over the knees or elbows often have a wrinkled, papyraceous appearance similar to that of the scars of this syndrome. Pseudotumors of varying sizes, present in the scarred areas, are, however, distinctly characteristic of the Ehlers-Danlos changes. Although a history of similar conditions in members of the patient's family is helpful in diagnosis, sporadic cases of the complete syndrome have been reported.

As emphasized before, changes may be limited to certain areas of the body, and some of the cardinal signs of the syndrome may be missing. Findings on palpation of the skin as described and fragility of the skin are most suggestive in diagnosis. Changes in the joints without changes in the skin are unlikely. Since reports of findings in this condition as a result of biopsy of the skin vary widely, and since involvement may be limited as to degree or area, information gained from microscopic sections of tissue may be of questionable value, in some cases.

This condition is coming to be recognized more often in all fields of medicine, especially the formes frustes types. In the past year, I have seen 2 other military cases, in which there were only changes in the skin with minimal fragility. Several years ago I saw a civilian patient with pronounced changes in the skin and joints, but without pseudotumors. Her brother had similar involvement of the skin, but this was of a lesser degree; his joints were normal.

Summary

The Ehlers-Danlos syndrome is an unusual clinical condition manifested by (1) hyperelasticity of the skin; (2) fragility of the skin and blood vessels; (3) pseudotumors over bony prominences related to fragility of the skin and trauma; (4) hyperlaxity of the joints; and (5) movable, subcutaneous, fibrocalcific nodules.

The condition is variable, and some of the cardinal signs may be minimal or absent (formes frustes).

The etiology is unknown. It may be familial or sporadic. It is transmitted by a Mendelian dominant inheritance pattern in some cases.

Reports of biopsies of the skin describe a wide variation in histopathologic findings as regards the elastic and collagenous fibrils. Elastic fibrils are usually increased.

Treatment consists of measures to protect the skin from trauma; supports to joints, if necessary; special care in suturing lacerations; and pressure bandages to contusions to prevent formation of pseudotumors.

A case in a military patient is reported.

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ABSTRACTS

Granulosa Cell Carcinoma of the Ovary: Clinical and Pathological Review of Seventeen Patients. By Howard C. Duckett, M.D., C. D. Davis, M.D., and B. F. Fetter, M.D. Obst. & Gynec. 2:611-618 (Dec.) 1953.

A series of 17 cases of granulosa cell carcinoma of the ovary, observed in the Gynecological Clinic at Duke Hospital over a period of 17 years, is reviewed and analyzed. The discussion covers age, race, symptoms, abnormalities of uterine bleeding, pathology, associated pathology, malignancy, treatment and results.

In summary, it was concluded that the degree of malignancy in granulosa cell carcinoma is less than that in ovarian carcinoma generally. Five, or 29.4 per cent, of the patients in the series succumbed to carcinomatosis. The incidence is the same for women in the premenopausal and postmenopausal period and more common after the age of 40 years. This type of carcinoma is rarely encountered in childhood. There is no racial preference. Nine of the patients in the cases studied were white and 8 were Negro. Abnormalities of uterine bleeding are the characteristic manifestations of estrogenic activity. The degree of malignancy cannot be determined from the cytologic and histologic patterns. Evisceration of the pelvic genital tract is the treatment of choice, except in younger patients for whom unilateral oophorectomy may be chosen.

Sickle-Cell Anemia Complicated by Pregnancy: A Review of the Literature and Six Case Reports. By H. C. Duckett, M.D., and C. D. Davis, M.D. Am. J. Obst. & Gynec. 66:409-414 (Aug.) 1953.

Sickle cell anemia, a hereditary disease occurring only in the Negro race, is a chronic hemolytic anemia. To the 77 cases of sickle cell anemia complicated by gestation which they found in a review of the literature, the authors add 6 cases, which they describe. In the 83 cases there were 176 reported gestations and 100 successful pregnancies. In their 6 cases the patients experienced 19 pregnancies, in 10 of which some antepartum care was received at Duke Hospital.

In this series of 83 reported and collected cases only 56.8 per cent of the fetuses survived. The complications reported in the 176 pregnancies included infection of the urinary tract in 25, toxemia of pregnancy in 23, morbid puerperium in 21, pneumonia in 14, infection of the upper part of the respiratory tract in 8, thrombosis of the vascular system in 9, and infection of other types in 14. The maternal mortality was 22.8 per cent.

The conclusions were: All Negro obstetric patients who are severely anemic should be investigated for sickle cell anemia. The prognosis for the fetus is poor. Severe infections are common, and the incidence of toxemia is considerably increased. The maternal risk is grave.

Localization of Sites of Dehydrogenase Activity in the Cervix Uteri: Normal, Metaplastic and Neoplastic Epithelium and Cervicitis. By Alvan G. Foraker, M.D., Sam Wesley Denham, M.D., and Polinestor Aguilar Celi, M.D. Cancer 7:311-317 (March) 1954.

The study described in this report was undertaken to determine the sites and distribution of dehydrogenase activity in the cervix with relationship to growth as seen in metaplasia and in carcinoma, and under stimulus of inflammation. The material utilized consisted of tissue from 37 cervixes removed primarily for noncervical disease and carcinomatous tissue from 15 cervixes. Evidence of dehydrogenase activity correlated closely with sites of growth in both normal and abnormal epithelium as seen in this series. No qualitative or quantitative difference in manifestation of enzyme activity was found in neoplastic (invasive or noninvasive) epithelium, actively metaplastic epithelium, or the basal layer of normally maturing portio vaginalis epithelium.

Phenylephrine Hydrochloride in Paroxysmal Supraventricular Tachycardia. By Lieut. Commander Charles K. Donegan and

Lieut. Charles V. Townsend, (MC), U. S. N. R. J. A. M. A. 157:716-718 (Feb. 26) 1955.

A case is reported in which a patient with paroxysmal supraventricular tachycardia was treated effectively with phenylephrine (Neo-Synephrine) hydrochloride after therapy with quinidine, digitalis, apomorphine, ipecac, and procaine amide (Pronestyl) hydrochloride had been ineffective. The drug stopped the arrhythmia, but produced short runs of ventricular tachycardia. The authors found that the same phenomenon had been recorded in the literature, but that no particular emphasis or attention had been given it. Since it is universally accepted that ventricular tachycardia, even in short runs, is potentially of serious consequence, they concluded that this complication deserves additional attention and that phenylephrine must be used with caution as a potentially dangerous agent in the treatment of paroxysmal supraventricular tachycardia.

History of Medical Hypnosis. By Walter W. Sackett Jr., M.D. South M. J. 48:306 (March) 1955.

In his chairman's address before the Section on General Practice, Symposium on Medical Hypnosis, at the St. Louis meeting of the Southern Medical Association last November, Dr. Sackett traced the history of hypnosis from Mesmer's theory of animal magnetism of two centuries ago to hypnosis of the present day. Interest in the phenomenon persisted during the nineteenth century, particularly in France. With the advent of psychoanalysis interest in hypnosis declined, but was renewed with the First World War because of its application in the treatment of shell shock. Since then a gradual reawakening of interest in this subject has taken place in the various fields of medicine. In retrospect, this author concludes, it is clear that Mesmer introduced a medical tool which has been gradually shaped and welded into what may hold untold possibilities for the future.

A New Diagnostic Procedure for Cancer of the Larynx Using a Retractable Throat Brush. By J. Ernest Ayre, M.D. J. A. M. A. 156:770-771 (Oct. 23) 1954.

The recent introduction of brush cytology into the field of gastric cancer diagnosis has stimulated the development of new methods that may permit the application of brush cytology to previously inaccessible tissues. The retractable throat brush (Ayre) described in this article is designed in such a way as to enable the rapid brushing of the vocal cords by a retractable brush that rotates through 360 degrees and so collects a rich concentration of cells and secretion for cytologic examination as a means of diagnosing benign and malignant growths. Malignant cell brushings, however, should be confirmed by histologic study prior to therapy. While local anesthesia of the throat may at times be indicated, the brush procedure is so rapid that the irritation resulting from its use is of short duration and it is well tolerated without anesthesia. In a test series of 142 cases in which the throat cytology was studied, cell brushings gave evidence of malignant disease in 16, and in 9 cases the results were classed as "suspicious." Histologic follow-up examination in 14 cases confirmed the positive findings in 10, and also in 2 of the suspicious cases.

The need for a screening method for early cancer of the throat has been emphasized by recent publicity on the importance of ruling out malignant disease in heavy smokers suffering from throat irritation. It is suggested that a simple technic such as that described here may play a useful role in annual cancer examinations and in examination of patients suffering prolonged hoarseness or throat irritation.

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Physicians and Medicine in Early Alachua County and Gainesville, Florida

Part II
War and Pestilence

Two events of 1835 left deep scars in their wake and made that year memorable. The worst freeze recorded in the history of Florida occurred on February 8 and 9, and the Seminole Indians massacred Major Francis Dade on December 28. The freeze killed virtually all the orange trees in the state and temporarily paralyzed business activity; the temperature dropped to 8 degrees above zero and remained below freezing for two days. Dade's massacre marked the onset of the Seminole War, which lasted more than six years, caused the death of many men, and brought further paralysis of commercial activity throughout a large part of the state.

In that eventful year Dr. George Morton Payne* arrived at Micanopy to begin the practice of medicine.[1] Following sharp skirmishes with Indians, the fort at Micanopy was abandoned during the summer of 1836,[2] and a military post was not established there until April 1837,[3] while the Post Office was discontinued in the fall of 1837 not to be re-established until 1842.[4] At times the little town was virtually deserted. It is not known how Dr. Payne was able to carry out his duties as a physician during those harassing years. Army surgeons shared his labors for a time during their service with army posts in the region, but with movement of their troops they were transferred, leaving him alone to serve the sick in the whole region.

Many orange growers between Jacksonville and Fort King, later Ocala, became discouraged by the devastating effect of the severe freeze and turned to other occupations, but not Dr. Payne. He apparently was among the first in the central portion of the state to recognize the advantages of raising sweet oranges rather than the bitter-sweet. He obtained seed from selected china fruit, planted them on the old Crosby place, later the location of Mrs. George Shuford's home, grew several trees, and began to distribute the fruit throughout the territory he served. As a result good seedling groves sprang up everywhere. At that time sweet seedling fruit was recognized as being an uncertain crop, but the trees from the

*Not to be confused with his son, Dr. George Booker Payne, who came to Micanopy in the late 1840s and lived there until his death in 1859. Dr. George B. Payne had two half brothers, Drs. John and Nettleton Payne, who lived and practiced medicine near Orange Lake before the War Between the States.[5]

seed of Dr. Payne's fruit apparently bore regularly and at an earlier age than most sweet seedling trees. His pioneering adventures with this new fruit have been credited as furnishing the revival of the orange industry in the region extending from Alligator, now Lake City, on the north to Lake Weir on the south.

During the period just preceding the Seminole War, plantations in central Florida became more numerous, cotton was planted more extensively, and the planters and wealthier class became more prosperous. The little farmers and so-called squatters, however, did not make out so well. They lived in crude huts with dirt floors, simple windows and mud chimneys. Their fare is said to have consisted chiefly of "corn pone, clabber, dried beef, venison and wild honey. Sometimes they had salt pork and coffee."[6]

The northern part of Alachua County developed during that period at a faster pace than the southern. The site of the county seat, which had been established at Newnansville in 1828, had been changed to the "House of Edward Dixon" in 1832 when creation of Columbia County from Alachua County placed Newnansville in the new county. In 1839, however, by adjustment of county boundary lines, Newnansville was placed in the extreme northeastern portion of Alachua County and re-established as the county seat.

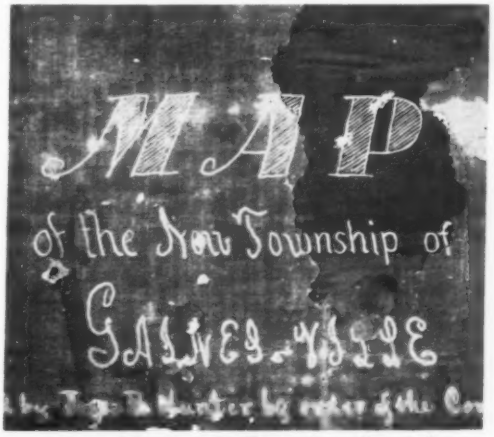
Recovery following the Seminole War came quickly. From 1842 until the outbreak of the War Between the States, Florida grew rapidly. Under the Armed Occupation Act of August 4, 1842, the Federal Land Office granted "a quarter section of land to heads of families and single men over eighteen years of age, able to bear arms, who should, within one year of the passage of the Act, make an actual settlement in the part of Florida lying south of a line from Palatka through a point about 10 miles south of Newnansville."[7] This inducement appeared to start a shift of population density from northern toward middle and southern Alachua County.

Gainesville Founded

During the early 1850s, plans for the Florida Railroad, which was to be built from Fernandina to Cedar Key, showed that it would miss Newnansville and would pass through the central part of the county near the Hog Town district. By 1852 residents in that area were making plans for a new town, which they hoped would become the county seat as well as a center for trade and commerce.[8] Those citizens doubtless were responsible for an act passed by the state legislature that year which provided for a county-wide vote whereby the people might select a new county seat.[9] Apparently as a result of that act, all citizens of the county were invited to a barbecue and picnic at Boulware Springs, just east of the site of the Gainesville water works today, to settle by vote the question of the site of the county seat and a name for the new town. A contest is supposed to have developed between those who wanted the town named Gainesville for General Edmund P. Gaines of Seminole War fame and those who wanted to name it Lewisville for a prominent planter in the Hog Town district. Major James B. Bailey, an early settler in the central portion of the county, is said to have won the day by proposing that if they gained the courthouse for the new little town, it would be named Gainesville, and if they lost the courthouse, the town would be named Lewisville.[10]

Many years later, Mr. James Doig, an early settler, wrote that the town was not named for General Gaines, but was named Gainsville at the suggestion of Major Bailey because the eastern part of the county had gained the vote in the election.[11] This view seems to have been supported by the fact that from the time of the recording of the new town as the county seat on September 6, 1854, in the minutes of the county commissioners until December 12, 1859, the name was consistently spelled without the e, Gainsville.[12]

The first map of the town, however, carries the legend:



Surveyed by Jesse B. Hunter by order of the Commissioners September 17th, 1853.

Likewise, when the United States Post Office was established at the new little town on July 5, 1856, its name also was spelled with the e, Gainesville.[13] There can be little doubt that Gainesville

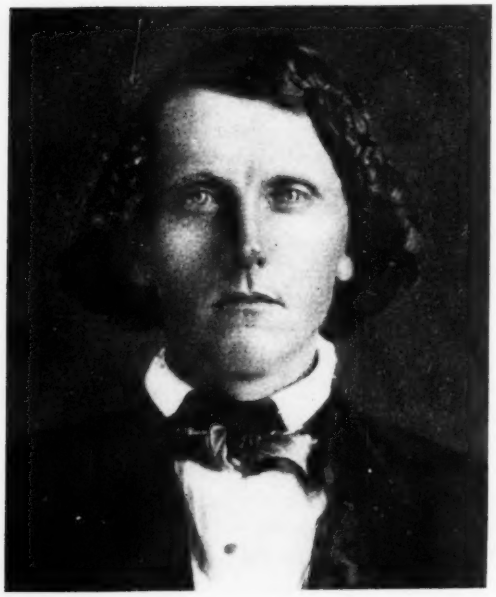


Fig. 1.— Dr. William H. Stringfellow.

was named for General Edmund Pendleton Gaines and that the spelling of its name has not been changed since the date of its founding.

Often it is difficult to say exactly when a town was born or began to exist. By general acclaim 1954 was appointed as the centennial year for the celebration of Gainesville's founding. Although there was not enough of a village there in 1855 to serve as a stopping point for a stagecoach which traversed that area between Micanopy and Newnansville and it was not large enough to be designated as a location for a United States Post Office until 1856, still efforts toward its founding had been begun several years before and that year, 1854, seems appropriate. The excellent cooperation given by Gainesville's citizens during the centennial year under the leadership of the Gainesville Sun has resulted in preservation of valuable little-known material which otherwise might have been lost. During that year, Charles H. Hildreth finished assembling his Gainesville historical material, a labor of love, in partial fulfillment of the requirements for a Ph.D. degree at the University of Florida. That scholarly history, a mimeographed copy of which is preserved at the P. K. Yonge Library of Florida History, will be a "must" for all who wish to study Gainesville's history during the first hundred years of the city's existence.

Land for the proposed town, some 100 acres, was bought from Major Bailey and the estate of Dr. Nehemiah Brush for less than $650.[14] The courthouse, completed in 1856, became the center of the town. Property around the courthouse square brought the highest prices and was most in demand. The entire block on South Main Street from University Avenue to Southwest First Avenue sold for $190.[15] Gradually stores, shops and hotels were built around this square.

Early Alachua County Physicians

During Gainesville's earliest years, three able young physicians, Drs. McCaa, Stringfellow and Thomas, chose the town for their homes and began the practice of medicine there. Dr. Gabriel Phillip Thomas, born in South Carolina on September 8, 1827, appears to have arrived in 1855 and to have settled near the center of the town. On October 10, 1856, he received title to the plot now occupied by Sears, Roebuck and Company at 14 South Main Street, and later he built a home on North Main Street. Father of Major W. R. Thomas and Dr. T. F. Thomas, two of Gainesville's best known citizens, Dr. Thomas lived in the little town and served the community for some 35 years until his death on August 8, 1890.[16]

Fig. 2.— Dr. Thomas Whitaker McCaa.

Dr. William H. Stringfellow[60] (fig. 1), born in South Carolina in 1818, arrived in Alachua County in 1856 and settled just west of Gainesville on the Newberry road at Fort Clarke, on what was later known as the Stringfellow plantation. He rode horseback for many miles to attend the sick. Also, he became interested in civic progress and the welfare of his community, induced the Reverend W. J. McCormick to locate in that section, and was largely responsible for the building of a Presbyterian church near Arredondo station and for the founding of the First Presbyterian Church in Gainesville. This pioneer physician was the father of three well known Gainesville residents, J. D. Stringfellow, T. B. Stringfellow and Mrs. Sallie R. Walker. Unfortunately, Dr. Stringfellow's health failed prematurely, and he was not able to be very active in his profession during the War Between the States and the reconstruction era. He died in Aiken and was buried in Union, S. C., in 1869.

Dr. Thomas Whitaker McCaa[61] (fig. 2), also a South Carolinian, was born on April 20, 1828. He settled beyond Sweetwater Branch, east of Gainesville, and appears to have become the best known and busiest physician of the territory during the early postwar era. At the height of his career he died of yellow fever in Gainesville on September 25, 1871, having contracted the disease in a neighboring town where he was called to attend patients suffering in an epidemic.

Gainesville was still a very small town in the late 1850s,[17] but it was beginning to show signs of substantial growth as was the county as a whole, which had a population of a little more than 8,000 in 1860.[18] The War Between the States, however, changed the whole outlook. Gainesville's citizens, eastside, westside and in the center of town, who had enjoyed unusually good medical attention for that day, soon apparently had no physician at all, then only one. Fortunately, however, there was no widespread or serious sickness during the war. In later years Dr. E. G. Clay of Fernandina wrote:

> I practiced in Gainesville and vicinity . . . from the summer of 1862 to fall of 1865. . . . I looked upon that whole country as exceedingly healthy, and what sickness there was, was of a mild type and generally very easily managed.[19]

One of several Alachua County physicians known to have had considerable active duty during the War Between the States was Dr. James Alexander Williams (fig. 3). Born in Charleston, S. C., on October 23, 1836, and graduated by Savannah Medical College in 1855, he had settled in Newnansville in 1856. Interested in surgery, he is said to have amputated the leg of a soldier without anesthesia following the Battle of Olustee.[20] In the book, Dickison and His Men, he is identified in a description of "The Battle of Gainesville" (fig. 4) as Captain Dickison's "noble surgeon . . . as brave a soldier as ever followed a leader into battle. . . ."[21] A successful planter and fruit grower as well as a physician,[22] he lived in Newnansville until his death on November 28, 1895.[23]

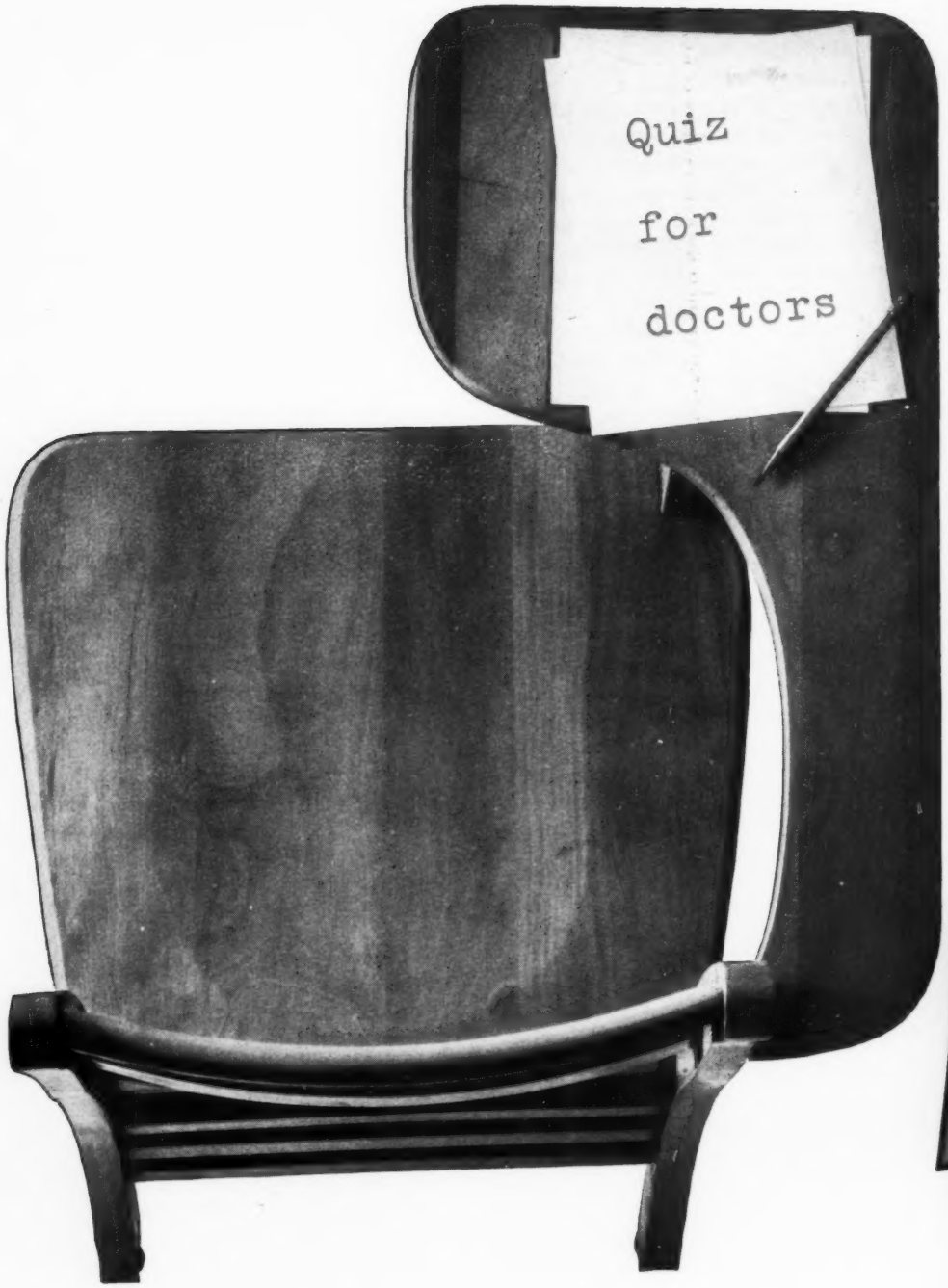
Fig. 3. — Dr. James Alexander Williams.

Another prominent young physician of Alachua County who played an unusually active part in the war was Dr. John Crews Pelot. Dr. Pelot, a member of the Florida legislature during its well know secession convention, volunteered his services from Alachua County as a private in 1862, but was soon made an assistant surgeon.[24] He had the unique experience of being physician and surgeon to the Andersonville, Georgia, Prison Hospital after its establishment in 1863. His manuscript articles describing his duty at "Floyd House Hospital and Andersonville Prison Hospital" have been preserved by Mr. John J. Pelot of Manatee, Fla.[25]

Postwar Progress

The New Era, a weekly newspaper, volume 1, number 1 of which was published in Gainesville on July 8, 1865, carried this message:

(Continued on page 304)


Quiz
for
doctors

(you probably know every answer!)

Q. Which is today's most widely prescribed broad-spectrum antibiotic?

A. ACHROMYCIN — it's first by many thousands of prescriptions.

Q. What are some of the advantages of ACHROMYCIN?

A. Wide spectrum of effectiveness.
Rapid diffusion and penetration.
Negligible side effects.

Q. Exactly how broad is the spectrum of ACHROMYCIN?

A. It has proved effective against a wide variety of infections, caused by Gram-positive and Gram-negative bacteria, rickettsia, and certain viruses and protozoa.

Q. In what way are ACHROMYCIN Capsules advantageous?

A. For rapid and complete absorption they are dry-filled, sealed capsules (a Lederle exclusive!) No oils, no paste...tamperproof.

Q. Who makes ACHROMYCIN?

A. It is produced — every gram — under rigid quality control in Lederle's own laboratories and is available only under the Lederle label.

ACHROMYCIN*

Hydrochloride
Tetracycline HCl Lederle

Lederle

LEDERLE LABORATORIES DIVISION AMERICAN Cyanamid COMPANY PEARL RIVER, NEW YORK

*REG. U.S. PAT. OFF.

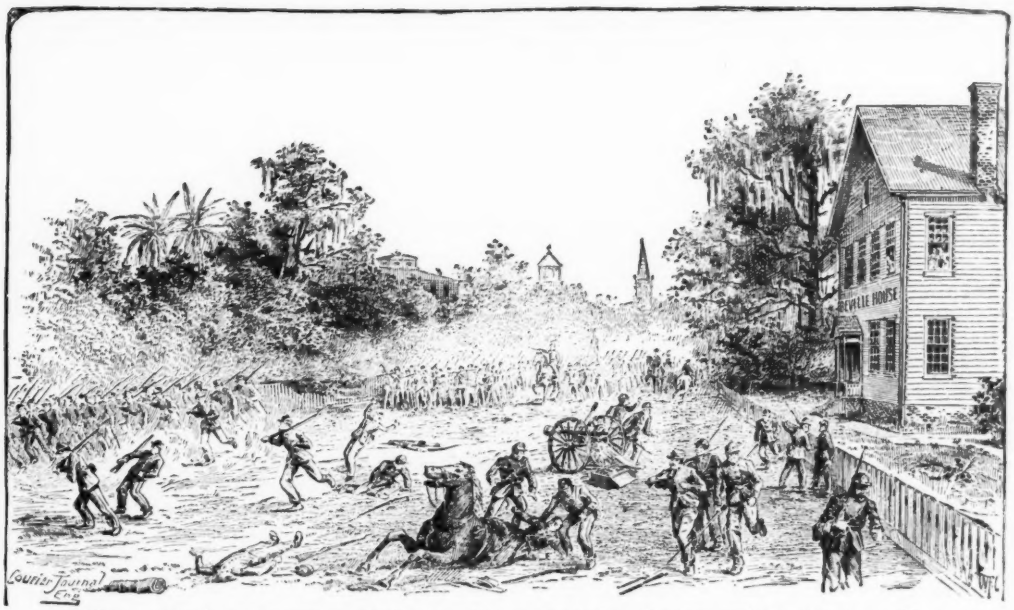


Fig. 4. — Battle at Gainesville, Florida, in 1864, as depicted in Dickison and His Men,[21] *p. 89.*

> The man who yields to the grim visage of despondency will not be prepared in the present emergency to act well his part in the coming drama of life. Try, then, to be cheerful; let us mingle again in the busy scenes as of old. . . .[26]

The following issue listed prices of articles in the Gainesville market with the statement that stocks were small, that money was scarce in proportion, and that country produce of all kinds found a more ready market than anything else. Selections from the list follow:[27]

Ale, per bottle, $1.00
Beef, per pound, 12½¢
Butter, per pound, 25¢
Coffee, per pound, 75¢
Eggs, per doz., 10¢
Lard, per pound, 15¢
Castor Oil, per quart, $2.50
Quinine, per oz., $7.50
Sulpher, per pound, 50¢
Saltpetre, per pound, $1.00

Soon Gainesville was making excellent progress commercially and business was actually booming. A note in the New Era during the fall of 1865 stated that the town was far ahead of other interior towns in the state in regard to trade.[28] The next spring the paper declared that Gainesville would be the controlling market for Alachua and Marion counties,[29] and in the spring of 1867 an article reported that no town in Florida had made more rapid progress following the war, that buildings were springing up like mushrooms and that new stores lined the streets.[30]

Yellow Fever

In 1871, the Florida Gazetteer stated that Gainesville was noted for its general good health; that hotels in course of erection were destined to be well patronized by invalids and pleasure seekers.[31] Until that time there had been relatively little illness. Smallpox had appeared in a nearby gulf coast town during the spring of 1866 and spread to Gainesville, but only a few cases occurred.[32] There had been a cholera scare at Jacksonville and Cedar Key during the fall of the same year,[33] and during the summer of 1867 an increased incidence of undiagnosed fever in Gainesville had made authorities fear an epidemic of yellow fever and order a general clean-up campaign.[34] The first epidemic of real proportions, however, occurred during the fall of the year 1871 and dealt the growing town a devastating blow.

The summer of that year was hot and wet. Rains were reported as continuous and copious.[35] The first case which resembled yellow fever appeared in Cedar Key on August 20, and the first death occurred there about September 1. At that time the little town, located on the Gulf of Mexico some 60 miles southwest of Gainesville, had a population of approximately 350, half of whom were white people. Cedar Key was recognized as being vulnerable to "contagious diseases" because

of the ships which docked there en route from Havana and Key West to New Orleans and because of the railroad which brought passengers from Fernandina and Jacksonville. In Cedar Key, however, as in other towns of the South during that period, facts concerning a suspected epidemic were concealed, for many held that it was better to suppress the truth than produce a panic. On Sunday, September 10, when six deaths occurred during that day and the night before, panic was of course the inevitable result. During the intense excitement everyone who was able to get away left promptly.[36]

Mr. L. F. Roux and Col. M. W. Downey, two sick refugees from Cedar Key, appear to have carried the fever to Gainesville. The first illness of this nature among the citizens there was that of a Mr. Dozier.[37]

A newspaper dated September 16 admitted that there had been four or five sudden deaths in Gainesville, but claimed that the town was still blessed with good health — that while their neighbors were suffering with disease and death and some were fleeing from their homes, Gainesville's citizens were enjoying the blessings of home and health.[38] At about that time, Dr. McCaa, who had been called to Cedar Key to attend the sick, became ill, returned to Gainesville, and despite the efforts of his physician friends, died on September 21.[39] The inscription on his gravestone reads:

Dr. Thomas W. McCaa
God's noblest work
An honest man.

Toward the end of September the epidemic began to die out in Cedar Key and in early October came to an end. An article in the Jacksonville Union, dated October 3, stated that only approximately 12 people were left at Cedar Key; that the railroad workmen were being kept at Otter Creek, 14 miles distant, and were being transported back and forth daily after sunup and before sundown.[40]

There seems to have been a blackout of news from Gainesville from late September until early November, when a correspondent from Gainesville was quoted in a Jacksonville paper as saying there was a malignant type of fever there which certainly resembled yellow fever and which in most cases was proving fatal.[41] Another letter from Gainesville, dated November 13, was quoted by a Savannah paper as saying that there were 40 cases of yellow fever in the little town and that there had been many deaths.[42] The New Era of Gainesville, dated November 11, stated there had been nine deaths that week.[43] Further information from Gainesville published in Jacksonville on November 16 admitted seven more deaths after November 12,[44] and the New Era published November 25 admitted that the fever was still afflicting Gainesville's citizens, that there had been more deaths, and that the epidemic had been "very fatal."[45]

On December 2, the New Era reported that the fever which had "swept off" so many of Gainesville's best citizens had materially abated because of cool weather[46] and on December 16 announced that several frosts and a good freeze having occurred, the few citizens who were still absent could return without further fear of "the late fatal fever."[47]

A total of 50 deaths are reported to have occurred,[48] a number which is startling when one considers the small population of Gainesville at that time. Apparently the mortality rate, and the total number of deaths as well, greatly exceeded those of the much better known yellow fever epidemic which occurred 17 years later, in 1888. Actually, this epidemic of 1871 has been almost entirely forgotten. It is still referred to by a few old Gainesville residents as the first epidemic to distinguish it from the second, but its date has been variously given as 1872,[49] 1876,[50] 1877,[51] and 1878.[52]

It was during this disastrous epidemic that

Fig. 5. — Dr. James F. McKinstry

local citizens observed that those who left town to sleep each night and returned during the mid-portion of each day were apt to escape the contagion and that among those who returned to the town and remained there one or more nights, there was a higher incidence of illness.

Postwar Physicians

During the year 1871 five physicians, besides Dr. McCaa who died in September of that year, practiced in Gainesville.[53] Of these, Dr. R. Y. H. Thomas, who practiced with his brother, Dr. G. P. Thomas, stayed only a short time before moving to another locality in Florida. Dr. George A. Penny and Dr. J. H. Verdier, not very well known, did not stay long. Fortunately, however, Dr. James F. McKinstry (fig. 5), 14 years younger than Dr. McCaa, became a life-long resident and outstanding citizen as well as an able physician and worthy successor to Dr. McCaa.

Born in Winnsboro, near Columbia, S. C., on December 17, 1842, Dr. McKinstry moved to Alachua County with his parents when he was hardly four and settled near Newnan's Lake. He served during the War Between the States, was graduated by the Long Island Medical College in 1866 and on September 12 of that same year was married to Miss Isabelle McCall, the daughter of Stephen McCall, one of Gainesville's pioneer residents.[54]

In early 1867, Dr. McKinstry practiced for a short time as an associate of Dr. G. P. Thomas.[55] In May of that year he announced that he had a building on the town square for rent, suitable for an office.[56] That office apparently is the same as the one he occupied in 1872 on Liberty Street, now University Avenue, near East Main Street, North, now Northeast First Street, shown in figure 6.

Affectionately known as Dr. Jim to distinguish him from his son, who was known as young Dr. Jim,[57] Dr. McKinstry served his town and region with distinction during the yellow fever epidemic of 1888.[58] He practiced with young Dr. Jim for many years in an office on North Main Street across from the old Atlantic Coast Line Railroad station.

After he had been appointed Postmaster at Gainesville in 1915, he announced his retirement as a practicing physician with these words:

> I sever the old relations with profoundest regrets; but I speak no goodbye, for the heart like the mind, hath its own memories and enshrined there I shall carry [these memories] with me into the Beyond.

Active in mind and spirit until the end, he was working among his flowers in his garden on the day of his death in 1926.[59]

Fig. 6.—Gainesville about 1872. Buildings on the north side of the Square on what is now University Avenue between Main and Northeast First streets. From left to right: 1. Shoe store of J. D. Matheson. 2. Office of Dr. J. F. McKinstry with Dr. McKinstry standing in the doorway. 3. Post Office. 4. Drugstore of R. C. McCall, later sold to Dr. A. J. Vidal. Upstairs was located in 1876 the office of the Gainesville Times, predecessor of the Gainesville Daily Sun, where articles were written, type was set, and the paper was printed, all by hand.

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Practical Program of Public Relations
Five Major Aspects

IV. Working With Others

Patients are people. The physician who thinks of them as numbers or cases or examples of some particular disease is out of tune with modern medicine. As mentioned last month in the third of this series of editorials on the practical public relations program of the Florida Medical Association, the doctor specializes primarily in people. The very nature of his profession requires him to make a business of people. Fortunately, the science of medicine and the art of medicine are so happily wedded today that the physician views his patient in the light of the total personality. He keeps his attention focused on the patient, not merely as the site of a disease, but as a human being, a member of a family and a community, beset with many problems, other than his immediate illness, which require advice and adjustment.

"The doctor is the friend, counselor and advisor to the family to whom he administers care," said Vice President Alben W. Barkley, addressing the Aero Medical Association in 1952. "I would rather have one country doctor working for me politically among my friends than anyone else. Doctors justify their profession and the confidence people give them."[1] Unquestionably, the practice of medicine qualifies as a training school in public relations. In the school of everyday experience the physician learns how to get along with patients in particular and people in general. He works, for example, with the Woman's Auxiliary, allied organizations, other professional groups, civic organizations and sponsors of community projects, organized labor, and state and independent agencies. These six groups form the basis of the Association's public relations program of working with others.

The Woman's Auxiliary is a most valuable asset to the public relations program. The activities of this energetic and enthusiastic group have been incorporated more and more into the local public relations pattern, and the Auxiliary members have rendered yoeman's service in carrying out many a project. They are peculiarly fitted and strategically situated to perform effectively their role in medical public relations. The Association salutes them.

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61. Letters from Mrs. Esther B. Jordan, Gainesville, Fla., and Mr. J. McCaa Haile, Jacksonville, Fla.; Matheson;[39] and interview with Mrs. A. E. Barker, Jacksonville, Fla.

Liaison and cooperation with allied groups constitute a particularly important aspect of the public relations program. These groups include dentists, druggists, nurses, medical assistants, medical technicians and others. Merely to enumerate them indicates the value of smooth working relations, which thrive in an atmosphere of harmony and understanding, and seek always to obtain the primary objective of the best medical care for the patient. A cheerful, considerate attitude on the part of the physician rarely fails to guarantee reciprocal cooperation from those who are as necessary to the physician in the practice of his profession as he is to them in the practice of their professions.

Likewise, liaison and cooperation with other professional groups, notably ministers and attorneys, make a most worthy public relations objective of physicians in this day of emphasis on the psychosomatic concept of medicine. If the total personality of the patient is to be served, as modern practice dictates, members of these other professional groups are not infrequently in a position to render invaluable aid. It is noteworthy, too, that in recent years liaison between the medical profession and, for example, the legal profession, as well as the allied professions of pharmacy and dentistry, has become closer, having received much stimulus through recognition of the threat of socialization and effort to stem the tide of this evil, whose proponents chose as their first target the practitioners of medicine. The guardians of the nation's health have found welcome support from other professional groups, which should be fostered and promoted continually in a never ending effort to keep the guard up against this threat that has by no mean ended.

The active participation by the physician in civic organizations and community projects pay big public relations dividends. In his role of Mr. Public Relations himself, mentioned in the preceding editorial of this series, the doctor has countless opportunities to inform the public of medicine's lofty ideals, worthy objectives and practical aspects, as well as to shape public opinion so that medicine's magnificent accomplishments, looking to the best medical care for all the people, will have fuller appreciation. While individually and in the aggregate the doctor is public relations, so to speak, he receives as well as gives. Student that he is, individualist that he prides himself on being, too long inclined to remain aloof, he is debtor to his relatively new role in public relations for contact and experiences beyond the scope of the immediate doctor-patient and personal social relationships, which have a broadening, seasoning, balancing influence that is inevitably reflected in his professional proficiency.

An advisory and liaison relationship with organized labor is a facet of public relations which promises much and merits assiduous cultivation. Amicable relations with labor organizations provide abundant opportunity for explaining the policies of the medical profession and its stand for free enterprise and health services on a voluntary basis. Understanding, in turn, will go far toward promoting full cooperation. Also, physicians engaged in the practice of industrial medicine have a unique opportunity to be special public relations emissaries.

Naturally, coordination and planning with state and independent agencies to maintain high health standards for the people of the state is a public relations duty which becomes a privilege. The rapport between the Association and the Florida State Board of Health, under the able leadership of Dr. Wilson T. Sowder, State Health Officer, is a notable example of rewarding public relations. Another is the Committee on Indigent Hospitalization, appointed by Governor Collins at the request of the Association. The efforts of this committee culminated in passage of a law at the recent session of the legislature which establishes state funds to match county funds for hospitalization of acutely ill indigent persons. Many instances of cooperation with independent agencies also might be cited.

The Association's practical program of public relations is in keeping with the positive program throughout the United States. That program has been a feature of the nation's medical progress which has given this country the world's highest standards of health and medical care. This progress has been achieved under a voluntary system which emphasizes free enterprise, individual initiative and responsibility, and cooperative effort. It has been accomplished by physicians, but not by them alone, for they have had the help and cooperation of the groups mentioned and, in addition, of many branches of science, hospitals, business, industry, education and all segments of American society. To medical public relations in Florida and throughout the nation falls the pleasant task of promoting this cooperative endeavor so that new heights may be scaled in the quest for the best medical care for all the people.

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Medical District Meetings October 10-14, 1955

The programs for the four Medical District Meetings have been announced by Dr. Ralph W. Jack of Miami, chairman of the Council of the Florida Medical Association, which sponsors the series of meetings. Arranged with the assistance of the eight district councilors, the programs are scheduled for October 10, 11, 12 and 14 at Fort Lauderdale, Lakeland, Gainesville and Pensacola respectively.

In charge of arrangements for the 16th annual meetings are the district councilors: Southeast District, Drs. Ralph S. Sappenfield, Miami, and James R. Sory, West Palm Beach; Southwest District, Drs. Coy L. Lay, Lakeland, assisting Councilor James R. Boulware Jr., Lakeland, and C. Frank Chunn, Tampa; Northeast District, Drs. Henry J. Babers Jr., Gainesville, and Charles L. Park Sr., Sanford, and Northwest District, Drs. William P. Hixon, Pensacola, and Walter J. Baker, Foley.

The general subjects for each of the four meetings are jaundice and blood. Scientific papers on various phases of the subjects are to be presented. However, the programs have been designed to be sufficiently diversified in order that the interest of general practitioner and specialist may be served.

Guest speakers for each of the four meetings are Dr. George T. Harrell Jr., Gainesville, dean, College of Medicine, University of Florida, and Dr. James J. Griffitts, Miami, president-elect, American Association of Blood Banks, and associate director of the John Elliott Blood Bank of Dade County.

Dr. Homer F. Marsh, Miami, University of Miami, School of Medicine, will also speak briefly at each meeting.

Following the precedence set by past Medical District Meetings, officers of the Association are to present brief addresses following the scientific program of each meeting. Officers scheduled to speak are Drs. John D. Milton, of Miami, President; Francis H. Langley, St. Petersburg, President-Elect; Samuel M. Day, Jacksonville, Secretary-Treasurer, and Shaler Richardson, Jacksonville, Editor of The Journal of the Florida Medical Association.

The meeting in Fort Lauderdale is scheduled to begin at 2:00 p.m. At 6:00 refreshments will be served followed by dinner at 7:30. The meetings at Lakeland and Gainesville follow this time schedule, while the one at Pensacola will begin one hour later, at 3:00 p.m., Central Standard Time, with refreshments being served at 6:30 followed by dinner at 8:00. Printed programs will be mailed to all members of the Association prior to the meetings.

The annual Workshops of the Woman's Auxiliary are to be held in connection with each Medical District Meeting. Each doctor's wife is urged to attend these informal sessions. Mrs. Samuel S. Lombardo, Jacksonville, president of the Auxiliary, has announced that the ladies in the Southeast District are to meet in the home of Mrs. Francis D. Pierce, 509 Isle of Palms, Fort Lauderdale, on October 10 at 2:00 p.m.; those in the Southwest District at the Lakeland Yacht Club on October 11 at 1:30 p.m.; those in the Northeast District in the Student Union Building, University of Florida, October 12 at 2:00 p.m., and those in the Northwest District in the San Carlos Hotel, Pensacola, October 14 at 3:00 p.m. Following the Workshop in each District, the ladies are to join their husbands for refreshments and dinner.

Scientific Assemblies — Four Medical Districts

Monday, Oct. 10 — 2:00 p.m.

Fort Lauderdale — D

Bahia Mar Club

Presiding: Ralph W. Jack, Chairman of the Council, and Ralph S. Sappenfield, of Miami, Councilor of District 8.

Address of Welcome, Ernest E. Serrano, President, Broward County Medical Association.

"Medical Aspects of Jaundice," George T. Harrell Jr., Gainesville.

"Surgical Aspects of Jaundice," Charles L. Wadsworth, Fort Lauderdale.

"Problems in Use of Blood and Blood Substitutes," James J. Griffitts, Miami, and John H. Mickley, Hollywood.

Tuesday, Oct. 11 — 2:00 p.m.

Lakeland — C

Lakeland Yacht Club

Presiding: Ralph W. Jack and James R. Boulware Jr., of Lakeland, Councilor of District 6.

Address of Welcome, Samuel J. Clark, President, Polk County Medical Association.

"Medical Aspects of Jaundice," George T. Harrell Jr., Gainesville.

"Surgical Aspects of Jaundice," Thomas E. McKell, Tampa.

"Problems in the Use of Blood and Blood Substitutes," James J. Griffitts, Miami, and Charles Catanzaro, Tampa.

Wednesday, Oct. 12 — 2:00 p.m.

Gainesville — B

Auditorium, Student Union Building, University of Florida

Presiding: Ralph W. Jack and Charles L. Park Sr., Sanford, Councilor of District 4.

Address of Welcome, Edwin H. Andrews, President, Alachua County Medical Society.

"Medical Aspects of Jaundice," George T. Harrell Jr., Gainesville.

"Surgical Aspects of Jaundice," Ashbel C. Williams, Jacksonville.

"Blood Transfusions," James J. Griffitts, Miami.

"Plasma and Plasma Expanders," Oscar W. Freeman, Orlando.

Friday, Oct. 14 — 3:00 p.m.

Pensacola — A

Pensacola Yacht Club

Presiding: Ralph W. Jack, and William P. Hixon, of Pensacola, Councilor of District 1, George T. Harrell Jr., moderator.

Address of Welcome, George W. Morse, President, Escambia County Medical Society.

"Surgical Aspects of Jaundice," Walter C. Payne Jr., Pensacola.

"Medical Aspects of Jaundice," George H. Garmany, Tallahassee.

James J. Griffitts, President-Elect, American Association of Blood Banks, Moderator.

"Blood Substitutes," Jack W. Fleming, Pensacola.

"Blood Transfusions and Reactions," Gerard H. Hilbert, Pensacola.

The Tumor Clinic and Cancer Registry

At the present time there are 19 tumor clinics in operation in Florida. These tumor clinics are operated by the local hospital staffs and have the approval of the county medical society concerned. Each clinic is financed by the American Cancer Society and the Florida State Board of Health. Space and other facilities are provided by the hospital concerned. All physicians that take part in the clinic donate their services.

The purpose of these clinics is to provide diagnostic services and treatment for those indigent cancer patients who offer a reasonably fair prognosis. The standards for the operation of the tumor clinic as recommended by the Florida Cancer Council and other agencies concerned are that the clinics meet the requirements of the American College of Surgeons.

A representative of the American College of Surgeons recently inspected 12 of the tumor clinics in Florida. He gave full approval of seven tumor clinics and provisional approval of five. No doubt the other seven tumor clinics will be inspected at a later date. The findings and recommendations of the inspecting officer have been submitted to each of the tumor clinics concerned.

The requirements of the College of Surgeons for the operation of the tumor clinics are being changed. On and after Dec. 31, 1955, each clinic should operate a Cancer Registry if it is to have the approval of the American College of Surgeons.

A manual for cancer programs, published by the American College of Surgeons, outlines the minimum requirements that should be met to get its approval. Copies of the manual are available either from the American College of Surgeons or from the Florida Cancer Council, Box 210, Jacksonville. Below are some of the requirements and purposes of the Cancer Registry as outlined in the manual:

"In general the purposes of the registry are as follows:

"1. To record from a specified date the name of every patient with cancer or suspected cancer admitted to the in- or outpatient services of the hospital, thus building a master file for the entire hospital cancer case load.

"2. To have available a file of medical record abstracts with the details of diagnosis, treatment and follow-up of each cancer patient for teaching, evaluating, research or reporting purposes, according to volume and facilities involved.

"3. To have a systematic means of establish-

ing regular follow-up of every cancer patient to keep him under adequate medical observation as long as he lives. Inherent in this objective is the addition of the follow-up information to the abstract of the patients.

"4. To have available the data on cancer for annual reports, or reports to the medical staff, or where the volume warrants it for more comprehensive statistical analysis.

"5. The minimum content required of each registry is the name and address of every patient, private and public, inpatient and outpatient, upon whom a diagnosis of cancer is or has been previously made, with adequate identifying and diagnostic information, with a basic abstract of the clinic record and an annual follow-up note for as long as the patient remains alive. From this base, the content may be elaborated as far as those conducting the registry desire.

"If at all possible, the registry should be assigned an office of its own physically available to the record office and the cancer clinical activities. In smaller hospitals the registry office activities may be conducted in direct association with the cancer clinical activities' office."

It is realized that if the Cancer Registry functions as it should, it will require the support of every physician on the hospital staff. It will mean that each of us should be more thorough in writing up our clinical histories, physical findings, operating procedures, and treatment rendered to patient. One of the main purposes of having a cancer registry is to make it possible for the staff members of the hospital to evaluate their own treatment procedures in comparison with other fellow staff members or in comparison with other treatment centers. The information kept in the Registry is considered of a confidential nature and should be made available only to the hospital staff concerned, according to the policies of the hospital. The Registry is intended to include private patients as well as charity patients. Through the Cancer Registry patients can be followed up and at the same time there need be no violation of the usual medical ethics. Through the Registry delinquent patients can be urged to return for further treatment if it is indicated and recommended by the attending physician.

It is believed that the American College of Surgeons should be commended in establishing the new regulations that have been recommended inasmuch as the Cancer Registry will provide each physician a means whereby he can evaluate his own services to the patient in comparison with those of his colleagues and thereby learn from his experience.

Plans are being made to have a meeting this fall of all of the tumor clinic directors, a representative of the American College of Surgeons, and representatives of the American Cancer Society and Florida Cancer Council, to offer detailed instructions on the operation, advantages and purposes of the Cancer Registry.

Hospitals in which tumor clinics are in operation are advised to make plans for the operation of a Cancer Registry if it has not already been done.

L. L. Parks, M. D.
Secretary, Florida Cancer Council

Graduate Medical Education Diabetes Association Daytona Beach, October 20-21

The third annual meeting of the Florida Clinical Diabetes Association will be held at the Princess Issena Hotel in Daytona Beach on October 20 and 21, 1955. The group is honored to have as its guest speaker for the dinner meeting on October 20 Dr. Otis L. Anderson, Assistant Surgeon General of the United States Public Health Service, who will give a "Progress Report on the Poliomyelitis Vaccine Program." Any physician desiring to attend this dinner may do so whether registered for the course or not. Advance reservations will be necessary and can be made at the registration desk in the Princess Issena Hotel.

The faculty consists of Dr. Joseph T. Beardwood Jr., Professor, Diseases of Metabolism, Graduate School, University of Pennsylvania; Director, Medical Services, Abington Memorial Hospital, Philadelphia, Pa.; Dr. Franklin Epstein, Assistant Professor of Medicine, Yale University School of Medicine, New Haven, Conn.; Dr. Fred Mathers, Orlando; Dr. George C. Austin, Miami; Dr. Samuel Wells, Jacksonville; and Dr. E. V. Anderson, Pensacola. The return of Dr. Beardwood to the program is most pleasing to the members of the Association. The subjects to be discussed by the faculty are varied and will be of interest to practically the entire medical profession.

The program of the Diabetes Association is being presented to precede immediately the annual meeting of the Academy of General Practice on

THIRD ANNUAL MEETING
FLORIDA CLINICAL DIABETES ASSOCIATION
PRINCESS ISSENA HOTEL, DAYTONA BEACH, OCTOBER 20-21

THURSDAY, OCTOBER 20 Moderator: Dr. Sidney Davidson, President

8:30- 9:00	Registration	
9:00- 9:15	Welcoming Remarks Dr. Robert L. Miller, President Volusia County Medical Society	
9:15-10:00	Diabetic Retinopathy	Dr. Beardwood
10:00-10:20	Diabetic Neuropathy	Dr. Mathers
10:20-10:30	Recess	
10:30-11:15	Clinical Correlates of the Kimmelstiel-Wilson Lesion	Dr. Epstein
11:15-11:35	Anesthesia for the Diabetic Patient	Dr. Austin
11:35-11:45	Recess	
11:45-12:30	The Surgical Diabetic Moderator: Dr. Joseph J. Lowenthal	Dr. Beardwood
2:00- 3:00	Fluid and Electrolytes in the Treatment of Diabetic Ketosis	Dr. Epstein
3:00- 3:15	Recess	
3:15- 5:00	Panel Discussion: Management of the Diabetic Patient Dr. Beardwood, Dr. Epstein, Dr. Mathers, Dr. Austin	
6:30	Dinner Meeting of the Association—Terrace Room, Johnston's Coffee Shop Guest Speaker: Dr. Otis L. Anderson, Assistant Surgeon General, United States Public Health Service	

FRIDAY, OCTOBER 21 Moderator: Dr. Richard H. Sinden, Incoming President

9:00- 9:45	Pregnancy and Diabetes	Dr. Epstein
9:45-10:30	Insulinomas of the Pancreas	Dr. Beardwood
10:30-10:45	Recess	
10:45-11:05	Hypoglycemia	Dr. Wells
11:05-11:50	Newer Concepts of Diabetes and Mechanisms of Insulin Action	Dr. Epstein
11:50-12:15	Juvenile Diabetes Moderator: Dr. Charles Donegan	Dr. Anderson
2:00- 3:00	The Prevention of Diabetes — Recent Thoughts on the Control of Obesity	Dr. Beardwood
3:00- 3:15	Recess	
3:15- 5:00	Panel Discussion: Management of the Diabetic Patient Dr. Epstein, Dr. Beardwood, Dr. Wells, Dr. Anderson	
8:00	Public Meeting: Daytona Beach Mainland High School Moderator: Dr. Robert L. Miller Speakers: Dr. Beardwood, Dr. Epstein, Dr. Anderson	

October 22 and 23 at the same hotel in Daytona Beach in anticipation that many of the members of the Academy will attend both courses. The rising incidence of diabetes mellitus increases the necessity for an awareness of this disease on the part of all physicians. Dr. Beardwood and Dr. Epstein will address the Academy on Saturday, October 22.

The Committee on Medical Postgraduate Course will make every effort to coordinate such courses in order that a larger group of physicians can attend without materially increased expenses or loss of time.

"Timely Topics"

A monthly publication of the Florida State Board of Health, entitled "Timely Topics," is intended for diabetic patients and is available to any physician who wishes his patients to receive it.

Written in language the average patient can understand, it should be helpful to all who receive it. Perhaps there are many members of the Florida Medical Association who will appreciate this reminder to make sure their patients with diabetes are getting it.

The June issue of this bulletin, for example, consists of an article which might be of as much interest to the average physician as to his diabetic patient. "Beware of 'Sure' Cures" is the title, but the author, Miss Marjorie M. Morrison, Chief Nutrition Consultant of the Board of Health, thought it might well have been called "In Defense of Doctors." Replying to the frequent criticism that doctors withhold information from the public or guard it too closely, she cites the Salk vaccine publicity with the reminder that Dr. Salk received no monetary remuneration and never claimed 100 per cent effectiveness for the vaccine. Likewise, Banting and Best made no money out of their discovery of insulin and claimed only that it would help the diabetic patient live with his diabetes.

In summary, "something sure is better than an advertised cure." Physicians do not make the lavish claims that are routine with fakers and food faddists. For that very reason, they are too frequently ignored in favor of the quacks who, with their clever sales talks, will offer their wares in the interest not of the welfare of man but of how much money they can extract from him.

Why are diabetic patients particularly susceptible to the wiles of quacks? One of the chief reasons, in the opinion of Wallace F. Janssen of the Food and Drug Administration, is dislike of the use of a needle for the administration of insulin. Freedom from the injections is too tempting a thought to withstand. Yielding to the blandishments of the quack may cost the patient with severe diabetes his life, and the patient with a mild or moderate form of the disease eventually learns the error of his choice.

"Why bring up all this anyway?" the article concludes. "Because Florida is fast becoming a mecca for food faddists and quacks. Health-restoring foods and medicines are being pushed to the public — more frequently on a door-to-door basis or "free lecture" plan than any other. It is an appeal to you to remember that when medical science makes a discovery such as insulin and polio vaccine, it is freely given to the public.

"A man's judgment is not any better than his information! Be informed about your diabetes by competent medical authorities."

New Drug Bottle Sets Dangerous Precedent

After all, there is something new under the sun. Seemingly with diabolical ingenuity, an eastern bottle company has thought up a new and surely unique product, which it is now marketing — a clown prescription bottle to be used by druggists in packaging medicine intended for children. No wonder a pharmaceutical manufacturer dubbed the whole idea "a silly merchandising promotion," to put it mildly.

"If it is so psychologically attractive to the child because of the bottle being clown-shaped, then will it not tempt the child to take more of the medication than the doctor prescribed?" he asked. "This temptation," he continued, "especially when parent or guardian is not around, creates an 'overdose situation' which can be very serious indeed." It is understandable that he urged someone to "kill the idea" because, as he said, "medicine is not a top!"

The clown prescription bottle was written up in a recent issue of the American Druggist at the same time a story emanating from the U. S. Food and Drug Administration was urging parents to "keep modern medicines out of their children's reach to avoid tragic consequences." The federal agency presently is concerned with the problem of protecting children against deceptive-looking medicines and has issued a call for a national conference of drug experts to study the matter.

In an editorial on a Florida study of the kerosene hazard to children, published in the April Journal, Katherine Bain, Associate Chief of the United States Children's Bureau was quoted as saying that "roughly two thirds of the deaths from accidental poisoning could be wiped out if aspirin, barbiturates, kerosene, lye, lead, and arsenic were unavailable to small children." The Florida Medical Association at its recent meeting endorsed the present effort of the Florida Children's Commission and the Florida State Board of Health to have a law enacted requiring proper labeling of small kerosene containers sold commercially. This measure should prove as effective as the state's lye legislation, passed years ago, in protecting children from these sources of poison.

Now along comes the clown prescription bottle to lure the child and prove a constant temptation. Will it become necessary to legislate that innovation out of existence? How commercial can we get?

STATE NEWS ITEMS

The fifteenth annual meeting of the Gulf Coast Clinical Society will be held in Pensacola on October 27 and 28, 1955. Approximately 400 physicians in general and specialty practice throughout Southern Mississippi, Southern Alabama and Northwest Florida will be in attendance. This meeting has been approved by the American Academy of General Practice for formal training requirements.

Guest speakers and their subjects on Thursday, October 27, include Dr. John C. Krantz Jr., Professor of Pharmacology, University of Maryland School of Medicine and College of Physicians and Surgeons, Baltimore, "Mechanism of Action of the Antibiotic Drugs;" Dr. W. K. Keller, Professor of Psychiatry, University of Louisville School of Medicine, Louisville, Ky., "Gynechiatry;" Dr. Max Michael Jr., Professor of Medicine, New York University College of Medicine, New York City, "The Patient with Fever of Unknown Origin;" Dr. J. E. Miller, Radiologist to the Baylor University Hospital, Dallas, Texas, "Angiocardiography;" and Dr. Grant E. Ward, Director, Tumor Clinic, Johns Hopkins Hospital, Baltimore, "Tumors Primary in the Neck." During the luncheon hour a round table discussion on "Etiology and Treatment of Bronchiogenic Carcinoma" is scheduled.

On Friday morning the guest lecturers and their subjects are: Dr. Edwin R. Levine, American College of Chest Physicians, Chicago, "Mechanisms Responsible for Recurrent Bronchopulmonary Infection;" and Dr. Lester R. Dragstedt, Professor of Surgery, University of Chicago, The School of Medicine, Chicago, "New Light on the Etiology of Gastric and Duodenal Ulcer." A clinicopathologic conference will be the closing feature of the program with Drs. Michael, Dragstedt and Miller, and Dr. W. A. D. Anderson, Professor of Pathology, University of Miami School of Medicine, Coral Gables, participating.

Dr. Walter C. Payne, of Pensacola, is president of this society, and Dr. Barkley Beidleman, also of Pensacola, serves as secretary-treasurer.

Dr. Joshua M. Price of Live Oak was honored by the Kiwanis Club there at a meeting held in August. Club members dedicated their meeting to him in recognition for his more than 50 years of service to the city and county.

Dr. Herman K. Moore of Key West was principal speaker at a recent meeting of the Lions Club of Key West. He recounted some of his experiences during a month's postgraduate course at Vienna, Austria.

Dr. Sidney Smith of Bradenton was guest speaker at a mid-August meeting of the Lions Club of that city. He discussed heart diseases.

Dr. Maurice Kovnat of Miami Beach delivered a scientific paper at the Third World Assembly of the Israel Medical Association held recently at Haifa. Dr. Kovnat is a member of the American Physicians Committee of the Association.

Dr. Albert Lehmann of Pensacola discussed the development of anesthesia and surgery at an early August meeting of the Rotary Club of that city.

Dr. John W. McClane Sr. of Fernandina Beach was principal speaker at the regular meeting of the Rotary Club there early in August.

Dr. Frank G. Slaughter of Jacksonville was featured speaker at a recent meeting of the Civitan Club of that city. The title of his address was "The Usefulness of Useless Knowledge."

Dr. David A. Newman of Palm Beach has returned from Boston where he completed a postgraduate course at the Peter Bent Brigham Hospital in that city.

Urologists from Clearwater, Tampa, St. Petersburg, Sarasota and Bradenton met in Bradenton early in August for the first in a series of meetings to be held by urologists practicing in this area. Dr. Frederic H. Wood of Bradenton was host to the group.

Dr. Wilson T. Sowder of Jacksonville was honored September 15 by employees of the State Board of Health on his tenth anniversary as state health officer. The theme for the hour long program was "A Decade of Progress." Speakers included Dr. John D. Milton of Miami, president of the Florida Medical Association, Dr. R. A.

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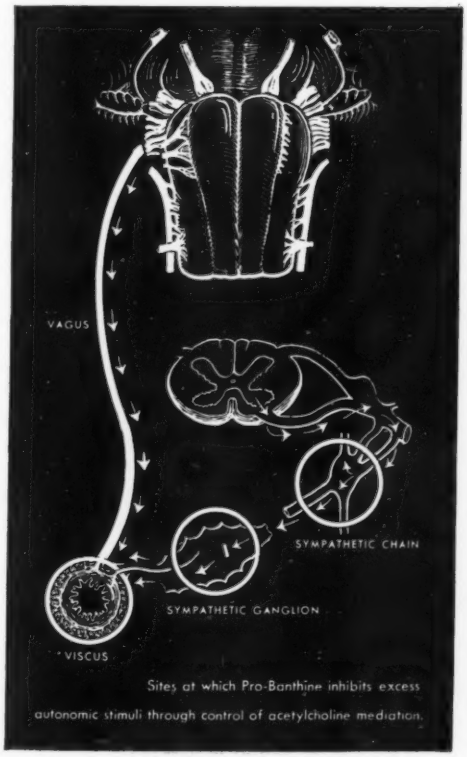
Pro-Banthine consistently controls gastrointestinal hypermotility and spasm and the attendant symptoms.

Pro-Banthine is an improved anticholinergic compound. Its unique pharmacologic properties are a decided advance in the control of the most common symptoms of smooth muscle spasm in all segments of the gastrointestinal tract.

By controlling excess motility of the gastrointestinal tract, Pro-Banthine has found wide use[1] in the treatment of peptic ulcer, functional diarrheas, regional enteritis and ulcerative colitis. It is also valuable in the treatment of pylorospasm and spasm of the sphincter of Oddi.



Sites at which Pro-Banthine inhibits excess autonomic stimuli through control of acetylcholine mediation.

Roback and Beal[2] found that Pro-Banthine orally was an "inhibitor of spontaneous and histamine-stimulated gastric secretion" which "resulted in marked and prolonged inhibition of the motility of the stomach, jejunum, and colon. . . ."

Therapy with Pro-Banthine is remarkably free from reactions associated with parasympathetic inhibition. Dryness of the mouth and blurred vision are much less common with Pro-Banthine than with other potent anticholinergic agents.

In Roback and Beal's[2] series "Side effects were almost entirely absent in single doses of 30 or 40 mg. . . ."

Pro-Banthine (β-diisopropylaminoethyl xanthene-9-carboxylate methobromide, brand of propantheline bromide) is available in three dosage forms: sugar-coated tablets of 15 mg.; sugar-coated tablets of 15 mg. of Pro-Banthine with 15 mg. of phenobarbital, for use when anxiety and tension are complicating factors; ampuls of 30 mg., for more rapid effects and in instances when oral medication is impractical or impossible.

For the average patient one tablet of Pro-Banthine (15 mg.) with each meal and two tablets (30 mg.) at bedtime will be adequate. G. D. Searle & Co., Research in the Service of Medicine.

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1. Schwartz I. R.; Lehman, E.; Ostrove, R., and Seibel, J. M.: Gastroenterology *25*:416 (Nov.) 1953.
2. Roback, R. A., and Beal, J. M.: Gastroenterology *25*:24 (Sept.) 1953.

SEARLE

Vonderleher of Atlanta, regional medical director, U. S. Public Health Service, and Senator Fletcher Morgan. Dr. Sowder was presented a gold watch on behalf of Board of Health employees.

Dr. Jack A. Sloane of Orlando entered medical service with the U. S. Army in June, 1955, with the rank of captain.

Dr. Robert G. Rosser Jr. of Jacksonville entered medical service with the U. S. Armed Forces on May 8, 1955, with the rank of major.

Dr. Louis Salhanick of Hialeah entered medical service with the U. S. Navy on August 30, 1955, with the rank of lieutenant commander.

Dr. Thomas Whitehead and Dr. James R. Nieder of Delray Beach were principal speakers at the mid-August meeting of the Rotary Club of that city. They reported on progress of the proposed hospital for south Palm Beach county.

COMPONENT SOCIETY NOTES

Dade

Dr. Robert E. Zellner, of Orlando, chairman of the Committee on Economics of the Florida Medical Association, was guest speaker at the September meeting of the Dade County Medical Association. His subject was "The Function of the Committee on Economics as It Pertains to Professional Liability Insurance."

Lake

Dr. Geoffrey H. Binneveld, of Leesburg, was principal speaker at the August meeting of the Lake County Medical Society. His subject was "Medicine in Korea and Japan." Dr. J. Basal Hall, secretary of the Society, reports that members have just completed the immunization and physical examinations for the National Guard Units. This is the eighth consecutive year that this public service has been rendered. He also states that the Society has a 100 per cent paid up membership.

Suwannee

Dr. J. Harry Hayes, of Little Rock, Ark., associate clinical professor of surgery and chief of thy-

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roid surgery at the University of Arkansas School of Medicine, addressed a meeting of the Suwannee County Medical Society on August 16. His subject was "The Diagnosis and Treatment of Thyroid Disorders."

The Society has paid 100 per cent of its state dues for 1955.

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Altman, Donald H., Miami
Bruce, John R., Jasper
Burke, Edward, Fort Myers Beach
Burroughs, Lyle W., Tampa
Gladsden, Norman, Miami
Henry, Richard A., Brooksville
Lesser, Milton E., Miami Beach
Menta, Julius D., North Miami
Reid, Robert W., Key West
Rumberger, Wilson A., Fort Myers
Russ, Zack Jr., Tampa
Yantis, Earl E., Ocala

BIRTHS, MARRIAGES AND DEATHS

Births

Dr. and Mrs. Seymour Morse of Jacksonville announce the birth of a son, Todd Fleet, on July 24, 1955.

Dr. and Mrs. Albert D. Rood of Jacksonville announce the birth of twin daughters, Debra Lynn and Rebecca Ann, on August 8, 1955.

Dr. and Mrs. David S. Kenet of Lakeland announce the birth of a son, Robert Owen, on July 11, 1955

Dr. and Mrs. Jacob Neber of Miami announce the birth of a daughter, Jennifer Frances on August 14, 1955.

Marriages

Dr. James B. Byrne of Coral Gables and Miss Catherine Frances Butler were married July 30, 1955, in Miami.

Dr. Benton B. Perry of Miami and Miss Roxanne Marilyn Mann were married July 24, 1955, in Baltimore, Md.

Deaths — Other Doctors

Ferguson, John A., Wyckoff, N. J.	June 9, 1955
Kline, Bernard, Mayview, Pa.	May 19, 1955
Maloney, Frank G. H., Madison, Wisc.	May 19, 1955
Porter, Joseph Y. Jr., Key West	August 7, 1955
Scheffel, Carl, Miami	July 18, 1955
Wonka, Warren J., Sarasota	July 19, 1955
Simpson, David J. (Col.), Lakeland	August 22, 1955
Ritch, Una F., Jesup, Ga.	Jan. 10, 1954
Myers, Dean W., Ann Arbor, Mich.	July 2, 1955
Byrd, Edwin S., Atlanta, Ga.	July 7, 1955

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KALAMAZOO
Indicated wherever oral cortisone or hydrocortisone is effective. Available in 5 mg. tablets in bottles of 30 and 100, and in 1 mg. tablets in bottles of 100. Usual dosage is ½ to 1 tablet three or four times daily
Delta-Cortef*
requires only 1/3 the dose of hydrocortisone
*Trademark for the Upjohn brand of prednisolone (delta-1-hydrocortisone)

Medical Officers Returned

Dr. William T. Steele, who entered military service on July 1, 1953, was released from active duty on June 30, 1955 with the rank of captain, U. S. Army. His address is Coker Building, Winter Haven.

Dr. David R. Rothrock, who entered military service on July 5, 1953, was released from active duty on July 5, 1955 with the rank of captain, U. S. Army. His address is 735 Opa Locka Blvd., Miami.

Dr. James D. Moody, who entered military service on July 2, 1953, was released from active duty on July 15, 1955 with the rank of captain, U. S. Army. His address is 4 E. Sturtevant, Orlando.

Dr. H. Herlong Adams, who entered military service on August 1, 1953, was released from active duty on July 31, 1955 with the rank of major, U. S. Army. His address is P. O. Box 852, Starke.

WANTED — FOR SALE

Advertising rates for this column are $5.00 per insertion for ads of 25 words or less. Add 20c for each additional word.

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WANTED: Physician with Florida license to assist in established industrial clinic, Jacksonville. Good starting salary with chance for advancement and opportunity to build own general practice. Write 69-159, P.O. Box 1018, Jacksonville.

SELL PRACTICE OR SUB-LEASE OFFICE: Owner specializing practice in another city. Write: Richard S. Lewis, M.D., 9812 N.W. 7th Ave., Miami, Fla.

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Appropriate to an age of mental and emotional stress,
EQUANIL has demonstrated remarkable properties for promoting
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EQUANIL is a pharmacologically unique anti-anxiety agent
with muscle-relaxing features.
Acting specifically on the central nervous system,
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tension states, and associated conditions.[1,2]
In clinical trials, patients respond with ". . . lessening of tension,
reduced irritability and restlessness, more restful sleep,
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It is a valuable adjunct to psychotherapy.
Clinical use is not limited by significant side-effects,
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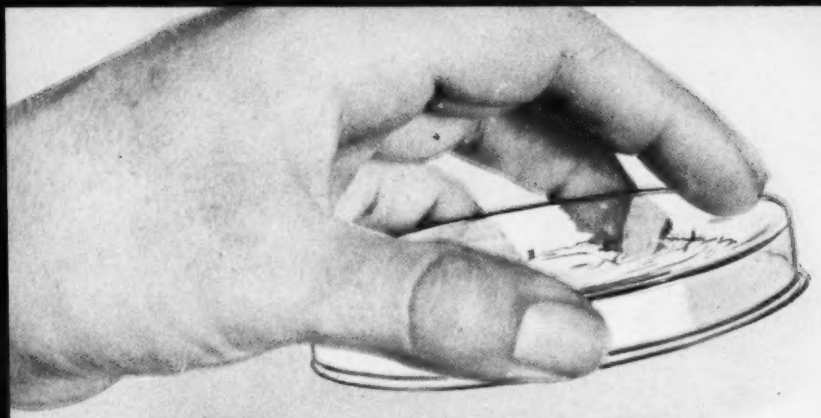
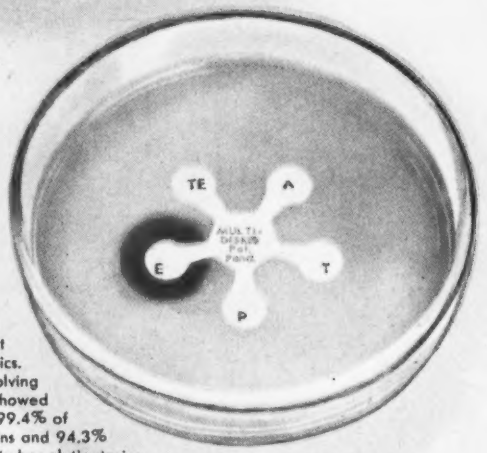
1. Selling, L.S.: J.A.M.A. 157: 1594 (April 30) 1955. 2. Borrus, J.C.: J.A.M.A. 157: 1596 (April 30) 1955.





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This blood agar plate shows a strain of *beta* hemolytic enterococcus. Note extreme sensitivity of this organism to ERYTHROCIN—yet it easily resists the other antibiotics. Additional data: A study[1] involving 202 enterococcic strains showed sensitivity to erythromycin in 99.4% of *alpha* hemolytic strains and 94.3% of *beta* hemolytic strains.

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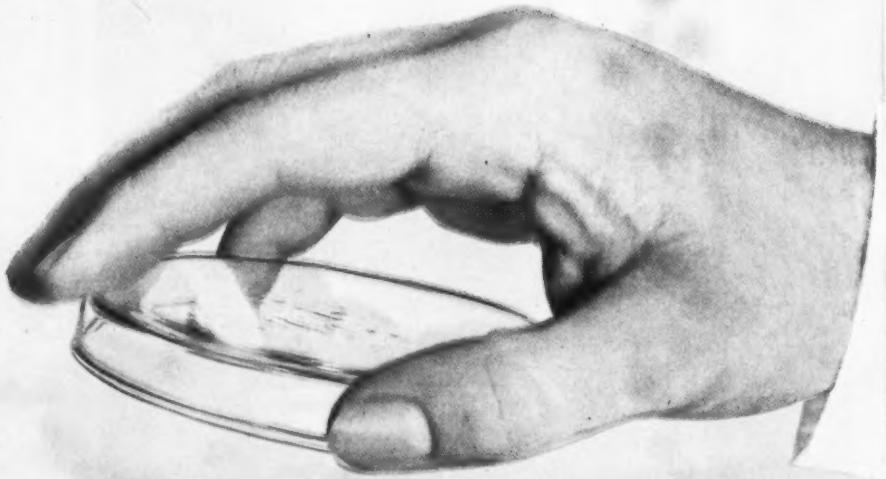

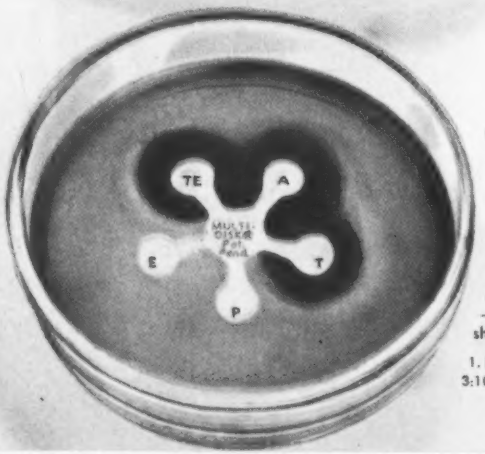

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This sensitivity test shows ERYTHROCIN and the same antibiotics against a typical intestinal strain of *E. coli*. Note that ERYTHROCIN and penicillin do not affect this gram-negative organism —although the other antibiotics show marked inhibitory action.

1. Eisenberg, et al., Antib. & Chemo., 3:1026-1028, Oct., 1953.

with little risk of serious side effects

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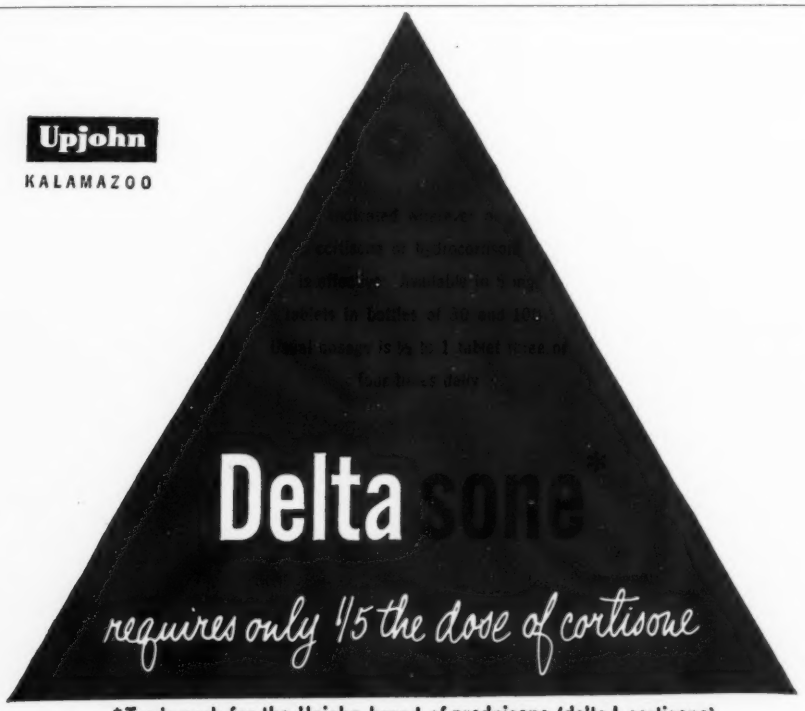
Medical Licenses Granted

Dr. Homer L. Pearson Jr., Secretary of the State Board of Medical Examiners, has reported that of the 354 applicants who took the examination of the Board, held June 27 and 28, 1955, in Jacksonville, 297 passed and have been issued licenses to practice medicine in Florida. The names and addresses of the 297 successful applicants follow:

Acton, Rush Keith, Miami, (Northwestern 1955)
Allen, John Darlen, Louisville, Ky. (Harvard 1941)
Anderson, George Arthur, Jacksonville (Bowman Gray 1947)
Anderson, Hildreth Vernon II, Knoxville, Tenn. (Louisiana State 1954)
Andrews, John William, Atlanta, Ga. (Emory 1955)
Andrews, William Wallace III, (Col.), Tampa (Meharry 1955)
Archer, Benjamin Lester, Homestead (Geo. Washington 1948)
Axler, Morton Mitchell, Miami Beach (U. Pennsylvania 1950)
Ayres, Thomas William, Shreveport, La. (Virginia 1950)

Babcock, Roy Huston, Sanford (Vanderbilt 1955)
Barish, Landis, Orlando (Hahnemann 1953)
Bass, Haskell Harris Jr., Bradenton (Tulane 1955)
Bechtold, John Edmond, Belleville, Ill. (Washington 1947)
Beck, John Edwin, Decatur, Ga. (Virginia 1939)
Behen, William C., Lansing, Mich. (Pennsylvania 1917)
Benson, Jerome, Miami (Creighton 1948)
Bergquist, Francis Layton, Key West (Arkansas 1949)
Birely, Beverly Robert, Fort Lauderdale (Maryland 1951)
Bitzer, Emory West Jr., Ocala (Virginia 1955)
Blackman, Allan Lee, New York (New York 1948)
Bonura, Charles Meyer, Fort Lauderdale (Tulane 1955)
Booher, David Oscar, Jacksonville (Jefferson 1949)
Boothby, Richard Joseph, Jacksonville (New York 1954)
Borken, Norman, Perry Point, Md. (N. Y. Med. 1949)
Bourne, Paul Samuel, Walkerton, Ind. (Indiana 1953)
Branch, David Louis Jr., Augusta, Ga. (Georgia 1954)
Brown, Glenn Crisman, Miami (Tulane 1953)
Brown, John Ollis, (Col.), Tuskegee, Ala. (Meharry 1950)
Brown, Marjorie Elaine Tweedt, Coral Gables (Marquette 1948)
Brown, Seymour, St. Louis (Washington 1940)
Bryan, James Randall, Augusta, Ga. (Georgia 1953)
Bunch, Rob Royce, Coral Gables (Washington 1952)
Burns, Emil Eddy, Atlanta, Ga. (Emory 1955)
Burnside, Charles Ray, Festus, Mo. (Washington 1951)

Cahn, Burton, Philadelphia (Hahnemann 1955)
Cain, William Joseph, Milwaukee (Marquette 1954)
Camp, Robert Judson, Miami (Virginia 1955)
Carey, Thomas Brandon, Lantana (Albany 1944)
Carney, Robert Tobias, St. Petersburg (Bowman Gray 1954)
Carter, William Everett, Nashville, Tenn. (Virginia 1946)
Cassady, John Rue, Park Forest, Ill. (Indiana 1953)
Cassidy, Robert Edward, New Orleans (Cincinnati 1953)
Catanzaro, Charles, Tampa (Jefferson 1946)
Cauble, John Archie, Atlanta, Ga. (Emory 1954)
Celano, Eugene Robert, Pensacola (Tulane 1955)
Cerrato, Calvin M., Braintree, Mass. (Bologna 1936)
Chambers, William Eldridge, Miami (Pennsylvania 1955)
Clark, George Alexander, New Augusta, Ind. (Indiana 1954)
Clements, Stephen Preston Jr., Boston (Harvard 1955)
Cofrin, David Austin, Gainesville (Cornell 1947)
Cohen, Richard Louis, Miami (New York 1955)
Coleman, Julian Barrus, Miami (McGill 1952)



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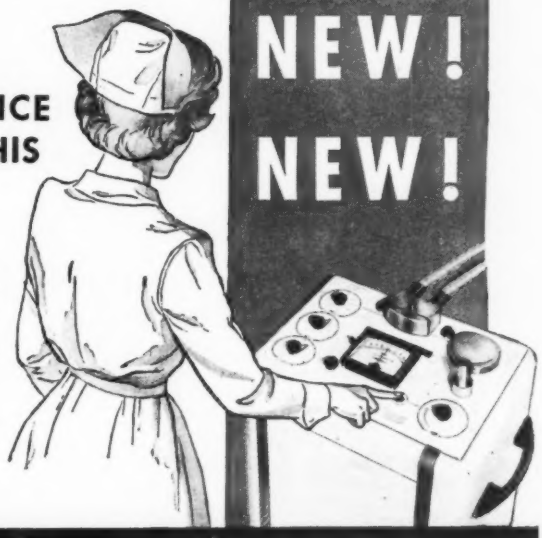

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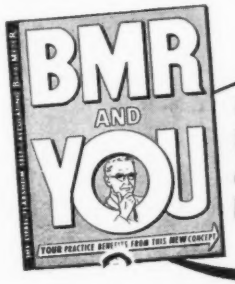

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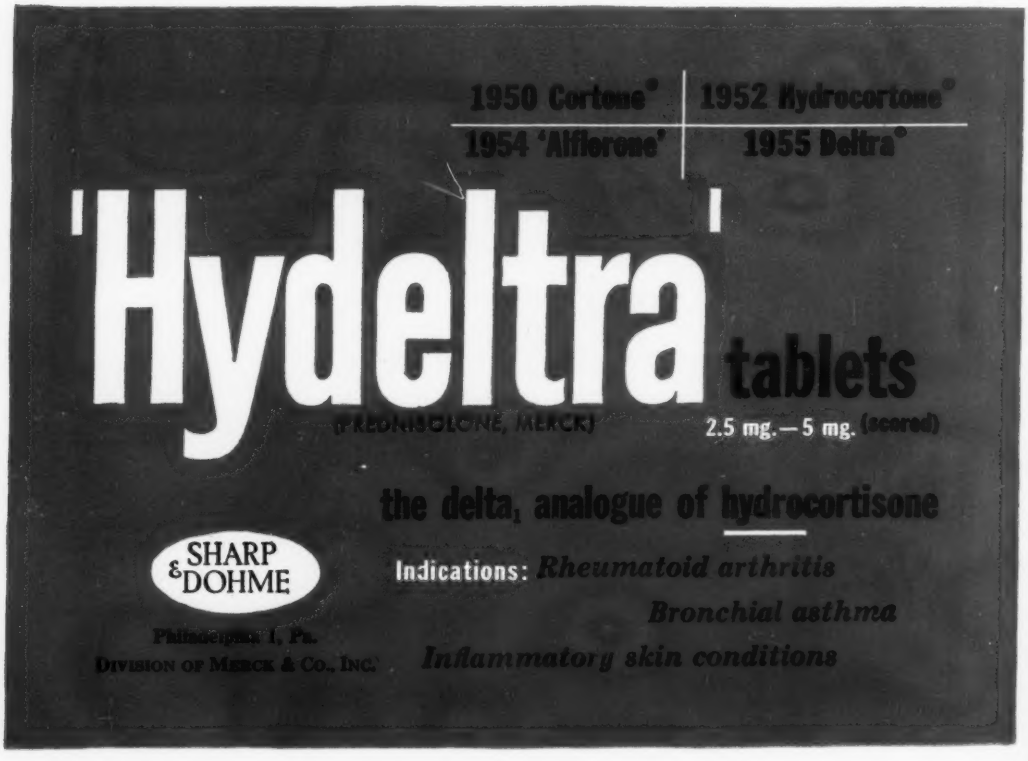
Collins, John Pope, Durham, N. C. (Duke 1944)
Cooper, William Calhoun Jr., Birmingham, Ala (Emory 1955)
Corey, Arthur Edwoode, Sanford (Tulane 1954)
Crane, Edwin Duff III, Atlanta, Ga. (Emory 1955)
Cranford, James Abram Jr., Jacksonville (Duke 1951)
Crider, Harry Jackson Jr., Orlando (Georgia 1951)

de la Penha, Daniel Simon, Augusta, Ga. (Georgia 1953)
Delgado, Robert Earl, Miami (Emory 1955)
Delman, Abner Joseph, New York (New York 1955)
Derry, William Hewitt, Miami (Colorado 1949)
Dickerson, Edzell Phenon, Orlando (Emory 1955)
Dobelle, Martin, Pittsfield, Mass. (Ghent 1934)
Doggett, Thaddeus Hill, Memphis, Tenn. (Tennessee 1947)
Donegan, Charles Coleman Jr., Charlottesville, Va. (Virginia 1951)
Donovan, Raymond Flowers, Watseka, Ill. (Illinois 1932)
Doster, John Roxie Jr., Jacksonville (Georgia 1952)
Douglas, Robert Arnold, Homestead (Maryland 1952)
Dyal, John Alexander Jr., Jacksonville (Georgia 1952)

Edgerton, Norman Bruce, Palatka (South Carolina 1943)
Erickson, George Matthews, Miami (Buffalo 1949)
Ewing, Channing Lester, Jacksonville (Virginia 1952)

Failla, John Anthony, Greenfield, Mass. (Boston 1939)
Faris, William Elbert, New Orleans (Tulane 1949)
Faust, William Raymond, Ocala (Temple 1955)
Featherston, John Smith, Key West (Geo. Washington 1946)
Feld, Harold, St. Petersburg (Cincinnati 1938)
Fergeson, James Oliver, St. Petersburg (Arkansas 1945)
Ferguson, James Henry, Miami (Pennsylvania 1939)
Fishel, John Lewis, Winston-Salem, N. C. (Duke 1953)
Flanagan, Curtis James, Miami (St. Louis 1952)
Fleming, William Henry II, Augusta, Ga. (Georgia 1951)
Fogel, Morris, Brooklyn (Boston 1936)
Forizs, Lorant, Butner, N. C. (Ferencz Jozsef 1936)
Fortunato, Stephen J., Providence, R. I. (Virginia 1937)
Foss, Harold Gregory, Chicago (Loyola 1951)
Foster, Donald Harvey, Pitman, N. J. (Jefferson 1954)
Foxworthy, Donald Lewis, Indianapolis (Indiana 1951)
Frankel, Donald Benjamin, Miami (Illinois 1942)
Frazier, Donald Benjamin, Jacksonville (Geo. Washington 1946)
Fritz, George Suppes, St. Petersburg (Maryland 1954)
Fuerst, Howard Jay, Montgomery, Ala. (Pennsylvania 1949)
Furlong, Paul James, West Haven, Conn. (New York 1951)
Galin, Miles A., Brooklyn (Bellevue 1955)
Gartner, Lee Darrell, Lincoln, Neb. (Nebraska 1949)
Geathers, Edward William, (Col), Winter Haven (Meharry 1954)
Geiger, Albert James Jr., Atlanta, Ga. (Emory 1955)
Gibson, Clyde Ellis, Bartow (Emory 1955)
Glattauer, Alfred, Brandenburg, Ky. (Zurich 1940)
Goldmeier, Erich, Perry Point, Md. (Frankfurt 1938)
Golia, Ernest Arthur, Bartow (Tufts 1940)
Gould, Purdue Leighton, Minneapolis (Washington 1948)
Graham, Angus Woodward Jr., Miami (Vanderbilt 1955)
Gray, Clell Claborne Jr., Miami (Cincinnati 1946)
Gregory, Laurence William, Sarasota (California 1925)
Griffin, Joseph Allan, Chicago (Loyola 1951)
Griffith, Henry Winter, Miami Springs (Emory 1953)
Guest, James Lee Jr., Atlanta, Ga. (Emory 1955)
Haddad, Maurice, Tampa (Beirut 1945)
Hahn, Theodore Wallace, Belle Glade (Louisville 1954)
Hall, Charles Clinton, Orlando (Evangelists 1954)
Hall, Kenneth Daland, Durham, N. C. (Duke 1953)
Hampton, John Bullock, Tampa (Emory 1955)
Hanks, Jack Billie, Atlanta, Ga. (Emory 1955)
Hardee, Erasmus Bacon Jr., Vero Beach (Virginia 1955)
Harle, Harold Lewis, Gainesville (Southwestern 1954)
Harrell, George Neville Jr., Plant City (McGill 1953)
Harris, Harry, Miami (Tufts 1924)



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A little Port or Sherry at bedtime affords a valuable aid to normal sleep and may obviate the need for sedative medication.

Recent results of laboratory and clinical research on the medical attributes of wine have been condensed into a small brochure entitled "Uses of Wine in Medical Practice." A copy is available to you—at no expense—by writing to: Wine Advisory Board, 717 Market Street, San Francisco 3, California.

Harris, Robert Scharff Jr., Miami (Tennessee 1954)
Harrison, Henry Tucker Jr., St. Petersburg (Virginia 1954)
Haupt, Clara Pucic, Gainesville (Pennsylvania 1940)
Hegert, Thomas Frederick, Orlando (Nebraska 1954)
Helfrich, Norman Alexander Jr., Jacksonville (Georgetown 1953)
Hobdy, Charlie Joe, Nashville, Tenn. (Vanderbilt 1955)
Hooper, Donald, Attalla, Ala. (Alabama 1954)
Hoover, Robert Theron, Orlando (Evangelists 1953)
Hopkins, William Benjamin Jr., Tampa (Harvard 1948)
Horton, James Allen, Live Oak (Louisiana 1954)
Huntley, Arthur Carson, Fort Lauderdale (Jefferson 1955)
Hurst, Ralph Emerson, Winter Park (New York 1949)
Hyams, Robert Gabriel, New York (Columbia 1939)

Iglesias, Robert Garcia, Tampa (Havana 1948)
Ira, Gordon Henry Jr., Jacksonville (Duke 1955)
Isaacson, Sherwin, Rochester, N. Y. (Chicago 1948)
Jackson, Andrew Rudolph, (Col.), Tampa (Meharry 1954)
Janulis, Peter Theodore, New York (Cornell 1951)
Jelks, Allen Nathaniel, Fort Lauderdale (Duke 1955)
Jenkins, William Jones, Augusta, Ga. (South Carolina 1943)
Johnson, Reginald Hall Jr., Durham, N. C. (Duke 1950)
Johnston, Harry Buchanan, Atlanta, Ga. (Georgia 1953)

Kaplan, Allan Arthur, Miami Beach (New York State Col. 1950)
Katibah, George Mitchell, Jacksonville (Emory 1955)
Keiser, Lester, Philadelphia (Jefferson 1950)
Kemp, William Lloyd, Birmingham, Mich. (Michigan 1953)
Kilgore, William Enloe, Ocala (Emory 1955)
Kimbell, Fariss Derring Jr., Warrington (Tulane 1946)
Kinsella, Dalton Louis Jr., Miami (St. Louis 1947)
Kirkman, Henry Neil, Tallahassee (Johns Hopkins 1952)
Klorfein, Elliott Harry, West Palm Beach (Tulane 1955)
Koenig, Alfred Daniel, St. Petersburg (Lausanne 1942)
Kruger, Harold Fred, Fort Lauderdale (Michigan 1940)
Kuhn, Charles Phillip, Miami Beach (Ohio State 1952)

Lamphier, Timothy Andre, Natick, Mass. (Boston 1943)
Larkum, Newton Wheeler, Hagerstown, Md. (Virginia 1941)
Lasche', Eunice Marie, Tampa (Temple 1948)
Leb, Herbert Scott, Miami Beach (St. Louis 1955)
Lees, Irving Balcom, Grand Rapids, Mich. (Long Island 1949)
Leonardy, John George Jr., Coral Gables (Emory 1955)
Lewis, Alfred Lawson Jr., Amite City, La. (Tulane 1954)
Lewis, Charles William Jr., Jacksonville (Duke 1945)
Lichtblau, Sheldon A., Long Beach, N. Y. (Chicago 1953)
Lien, Ira Jay, Miami Beach (Col. P. & S., Boston 1949)
Liles, Royall Thomas Jr., New Orleans (Tulane 1949)
Lockwood, Wayne Babcock, St. Augustine (Pennsylvania 1954)
Lopez, Joseph George, Miami (Louisiana 1948)
Lowrey, Daniel Bernard, Birmingham, Ala. (Washington 1950)

McCall, Ben Waring, Jacksonville (Duke 1955)
McCormick, John Theus, Jacksonville (Georgia 1953)
McIntosh, Charles Byron, (Col.), Jacksonville (Meharry 1955)
McKenna, Robert Joseph, New York (Cornell 1951)
McKey, Robert Milroy Jr., Miami (Vanderbilt 1955)
McVey, John Lovett, Newton Highlands, Mass. (Boston 1955)
Macris, Jack Achilles, Coral Gables (Michigan 1950)
Mabie, Paul David, Camp Lejeune, N. C. (Cincinnati 1954)
Major, James Moffat, Decatur, Ga. (Emory 1953)
Makol, James George, Springfield, Mass. (Beirut 1943)
Maxwell, William, New York (Long Island 1920)
Mazza, Peter Anselmo, Pelham, N. Y. (Italy 1933)
Mellion, Anson Joel, Jacksonville (New York 1954)
Melvin, Hiram Mack, Milton (Tulane 1955)

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Michele, Arthur Albert, Brooklyn (New York 1935)
Miles, Clifford Burton, Chicago (Northwestern 1952)
Miller, Andrew Herron, Columbia, S. C. (Tennessee 1947)
Miller, Hyman I., Kew Gardens, N. Y. (Middlesex 1943)
Millis, James Brown, Wabassa (Tennessee 1955)
Minor, Byron Donald, Atlanta, Ga. (Emory 1955)
Mitchell, John Lewis, Jacksonville (Emory 1955)
Mix, George Henry, Tacoma, Wash. (Buffalo 1947)
Moore, Louis Stone, Thomasville, Ga. (Zurich 1954)
Moore, Michael Judson, Virginia Beach, Va. (Virginia 1948)
Moore, Richard Benjamin Jr., Union City, Tenn. (Vanderbilt 1955)
Morton, Donald Gene, Miami Beach (Oklahoma 1953)
Murray, James Beverley, Willoughby, Ohio (Western Reserve 1946)

Nardone, Robert Rudolph, Beaufort, S. C. (Tufts 1947)
Neefe, John Robert, Philadelphia (Pennsylvania 1940)
Neill, James Robert, Coral Gables (Emory 1955)
Newton, Emory O'Neal, Bartow (Emory 1955)
Newton, Lyle Arford, Jacksonville (Nebraska 1930)
Nickell, Leo Carroll, Orlando (Louisville 1951)
Nogueiras, Humberto Mario, Miami (Havana 1949)

O'Brien, Fred Kevin, Palm Beach (Tulane 1955)
O'Conor, Gregory Thomas, W. Hartford, Conn. (Cornell 1948)
O'Neill, Philip Bernard, St. Simons Island, Ga. (Pittsburgh 1941)
Orestano, Andrew, Tampa (Tulane 1955)
Oyen, William, Winter Garden (Illinois 1949)

Padgett, Glenn Ernest, Marianna (Geo. Washington 1953)
Parker, Mayon Vann, Durham, N. C. (Duke 1953)
Patten, Robert Chester, Miami (Cornell 1954)
Patterson, Lawrence George, Waupaca, Wis. (Ohio 1931)
Pavlik, Charles Emanuel, Miami (Albany 1954)
Pendergrass, Henry Pancoast, Wynnewood, Pa. (Pennsylvania 1952)
Perloff, Milton Leon, Miami Beach (Hahnemann 1955)
Perry, Gerald Francis, Westbury, N. Y. (Madras 1943)
Peterson, Donald Laing, Hollywood (Minnesota 1933)
Phinizy, John, Lincolnton, Ga. (Georgia 1953)
Preefer, Charles J., Rockville Centre, N. Y. (Tufts 1930)
Pringle, James Copeland Jr., Montgomery, Ala. (Johns Hopkins 1953)
Pucic, Catherine Jean, Trafford, Pa. (Pittsburgh 1938)
Pund, Ernest Evers Jr., Augusta, Ga. (Georgia 1955)

Quarterman, Keith Axson Jr., Atlanta, Ga. (Emory 1955)

Raisbeck, Clifford Clinton Jr., Warrington (Northwestern 1953)
Raker, Ned Tyson, Lima, Peru, S. A. (Jefferson 1935)
Rattray, Charles Frederic Jr., Pineville, La. (Alabama 1954)
Rawls, Thompson Townsend, Rochester, Minn. (Harvard 1949)
Rechbook, Karl Yaskin, Miami Beach (Pennsylvania 1955)
Regan, Thomas Francis, Lake City (Pittsburgh 1946)

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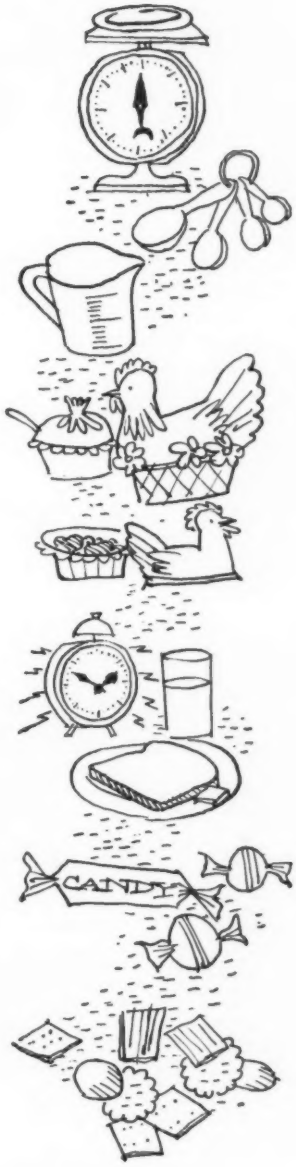
Making the Diabetic Diet fit...

Your patient may feel an outsider both at home and away from home when diabetes upsets his eating habits. Of course, a measured diet is vital. The trick is to fit that diet as closely as possible to the patient's personal preferences and way of life. Here are some diet "do's" to help in planning the menus.



At home—

Try to adapt favorite recipes to the diabetic diet. Then select vegetables, beverage, and fruit or dessert to complete the diet prescription for the meal.

Suggest that measured portions be served in dishes that fit the serving. A small portion on a large plate is not a happy prospect.

Where possible, let your patient use a food exchange list. He'll delight in the variations it provides.

Away from home—

Explain that insulin demands food with the urgency and regularity of an alarm clock. If a dinner party will be late, suggest a light snack at the usual mealtime with a corresponding caloric reduction in the delayed meal.

Allow extra carbohydrate for extra activity. And have your patient carry hard candies as a precaution against insulin reaction.

If possible, plan low-calorie wafers in the diet for times when others nibble canapés or chocolates.

A diet that fits in smoothly with your patient's family and social life means you'll have his fullest co-operation, and he'll lead a happier life.

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*Average of American beers

Rester, James Harvey Jr., Lantana (Louisiana 1944)
Rew, John Bernard, New Orleans (St. Louis 1953)
Richmond, Kenneth Comstock, Miami (Rochester 1954)
Ritch, Joseph George Jr., Stuart (Tennessee 1955)
Robinson, Joe Sam, East Point, Ga. (Georgia 1944)
Rogers, David Ross, Fort Lauderdale (Virginia 1948)
Rosenthal, Anna, Miami (New York 1948)
Rosenthal, Martin, Brooklyn (New York 1955)
Ross, Irwin Randall, Philadelphia (Hahnemann 1955)
Rowars, Howard, Whitestone, N. Y. (Munich 1936)
Ruder, Ernst Murphy, Clearwater (Emory 1955)
Russell, Albert Barnard Jr., New Orleans (Tulane 1955)

Salmon, William Davis Jr., St. Louis (Vanderbilt 1949)
Salvatore, Joseph Enrico, Philadelphia (Hahnemann 1955)
Sanford, Marshall Clement, Gibson Island, Md. (Johns Hopkins 1942)
Schiess, Retha Renee Rudloff, Miami (Bowman Gray 1953)
Schindler, Richard Elias, Miami (Maryland 1953)
Schmierer, Elmer John, Wildwood (Louisville 1954)
Schrantz, Freeman S., Miami (Tennessee 1940)
Schulman, Harold, N. Miami (Emory 1955)
Schutt, James Bourie, Ligonier, Ind. (Indiana 1931)
Schwalbe, Frank Conrad Jr., Baltimore (Emory 1955)
Scudder, Harry Greene, West Palm Beach (Temple 1952)
Shaver, William Alvin, Augusta, Ga. (Pennsylvania 1948)
Sheffel, Donald David, Miami (Leiden 1954)
Simons, Robert Baldridge, Warrington (Colorado 1934)
Skaggs, Thomas Wayne, Miami (Maryland 1953)
Smith, Ballard Franklin, Rochester, Minn. (Buffalo 1946)
Smith, Richard Brooks, New Orleans (Indiana 1944)
Smythe, John Welden, Winter Haven (Jefferson 1948)
Specht, Harry Otto, Indianapolis (Indiana 1948)
Stanton, Robert Lowell, Coral Gables (Temple 1953)
Stapp, Lee Mannen, South Miami (Emory 1955)
Stefan, Ladislav, Winter Haven (Prague 1945)
Stein, Benjamin Frederick, Mount Carmel, Ill. (Illinois 1941)
Steinmetz, Rodney Dunlap, Rochester, Minn. (Northwestern 1952)
Stephens, David Lamar, Tallahassee (Tulane 1949)
Stough, Dowling Bluford III, Tampa (Arkansas 1953)
Szekely, Gabriel, Miami Beach (Bologna 1935)

Tanis, Arnold Lawrence, Key West (Chicago 1951)
Tate, Charles Franklin Jr., Charlottesville, Va. (Virginia 1949)
Temple, Van Carlton, Hattiesburg, Miss. (Vanderbilt 1930)
Terragni, Manlio, Bronx, N. Y. (Bellevue 1915)
Thompson, George Allen, Bastian, Va. (Virginia 1954)
Toporoff, George Sherman, West Palm Beach (Pennsylvania 1955)
Trimble, James Rufus, Durham, N. C. (Columbia 1947)
Turnage, Johnson Lee, Crestview (Tulane 1942)
Turner, John Sidney Jr., Lakeland (Emory 1955)

Vadheim, Robert Harold, Gainesville (Minnesota 1944)
Van Arnam, Carleton Everest, Micanopy (Oregon 1953)
Van Eldik, Dick Leroy, Duluth, Minn. (Iowa 1952)

Wadsworth, Gerald Edward, Tampa (Emory 1955)
Ward, John Ardis, Shellman, Ga. (Emory 1950)
Watkins, Lee Clifford Jr., Rochester, Minn. (Harvard 1952)
Watson, William Newton, Milton (New York 1954)
Weekley, Augustine Smythe Jr., Tampa (Boston 1955)
Weeks, Clarke Bankston Jr., Lakeland (Emory 1953)
Weinstein, Pierce, Cocoa (Buffalo 1949)
Werner, Charles Arthur, Huntington, N. Y. (Cornell 1945)
Whorton, Carl Merrill, Jacksonville (Vanderbilt 1940)
Williams, Edward Herbert Jr., Jacksonville (Emory 1955)
Willig, Selwyn Gerald, New Orleans (Tulane 1954)
Wilson, Herbert, Fort Myers (Geo. Washington 1939)
Winter, Willian John Jr., Miami (Pittsburgh 1942)
Wright, Jack Elvin, West Palm Beach (Louisville 1954)
Wynne, Morgan Dozier Jr., Griffin, Ga. (Emory 1955)

(Continued on page 334)

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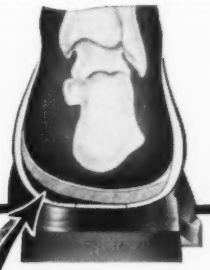

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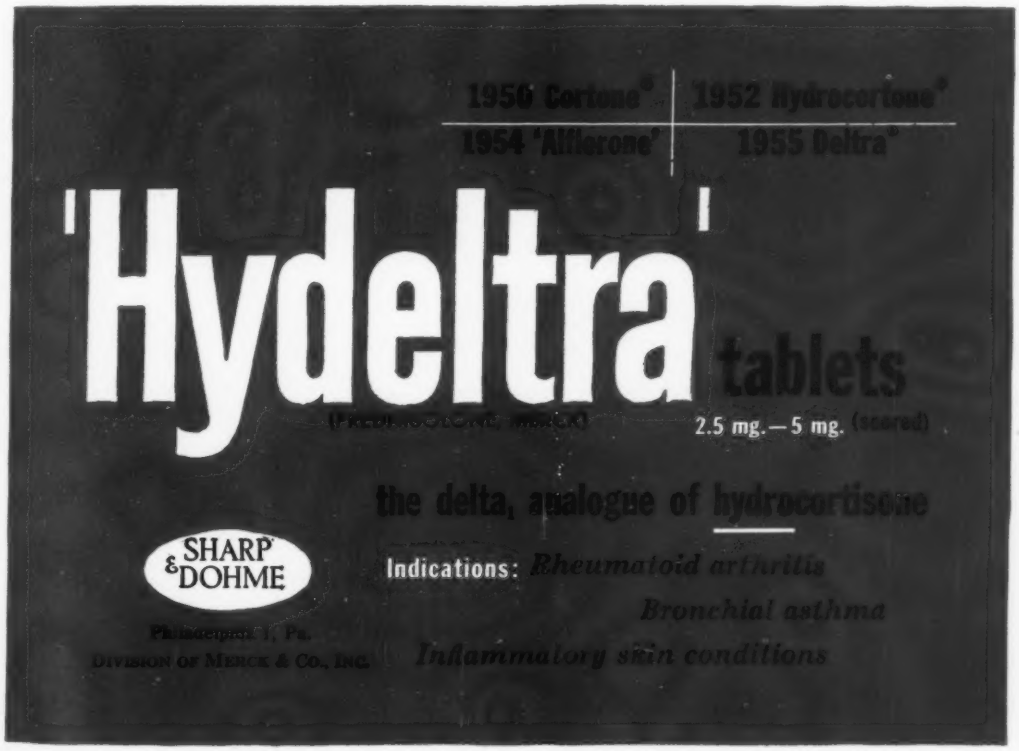
Practical Knowledge and Realistic Goals Urged by National Auxiliary

During August and the first part of September, programs from the national auxiliary chairmen are sent to every county auxiliary chairman and president urging them to take part in those projects set up at the national level and making suggestions for the augmentation of these programs. In almost every instance, the program has two major aspects — personal knowledge and information and secondly, aid to the community through putting this personal knowledge to use as it applies to our own home towns and communities.

The themes of the national auxiliary have varied from year to year but some of these of the last few years indicate the two major purposes of all national auxiliary programs and here are some examples: *Be an Informed Member, Every Member an Informed Member, Together We Progress, Leadership in Community Health* and the theme chosen by Mrs. Mason G. Lawson for 1955-56, "Active Leadership in Community Health." The sense of the two major aspects is self-evident. To

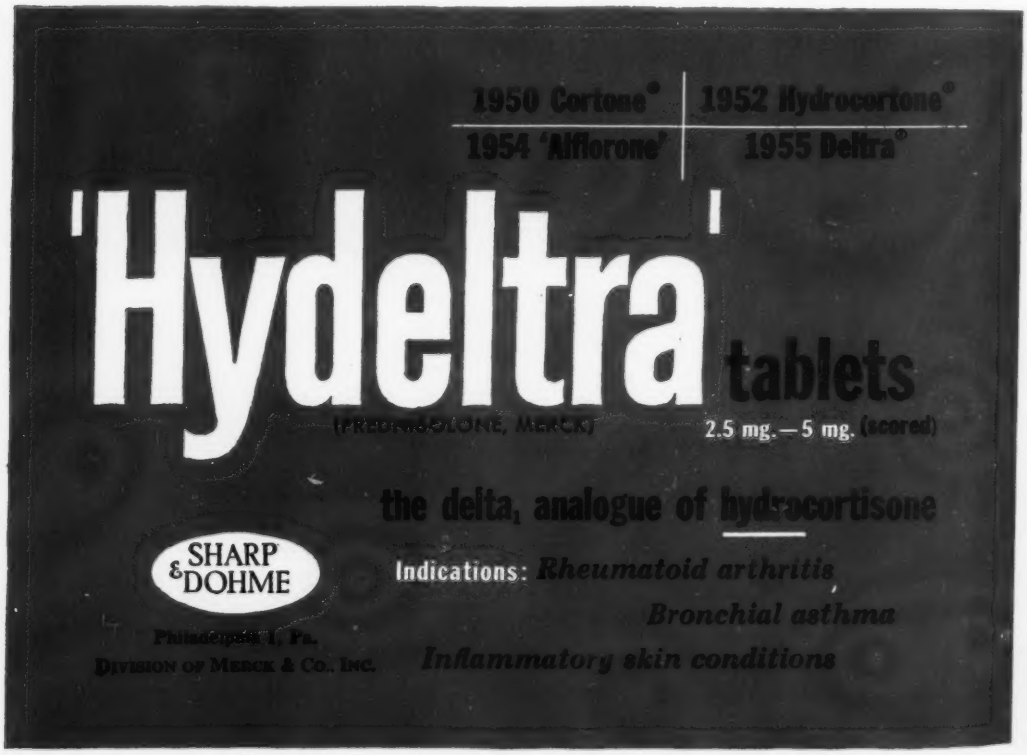


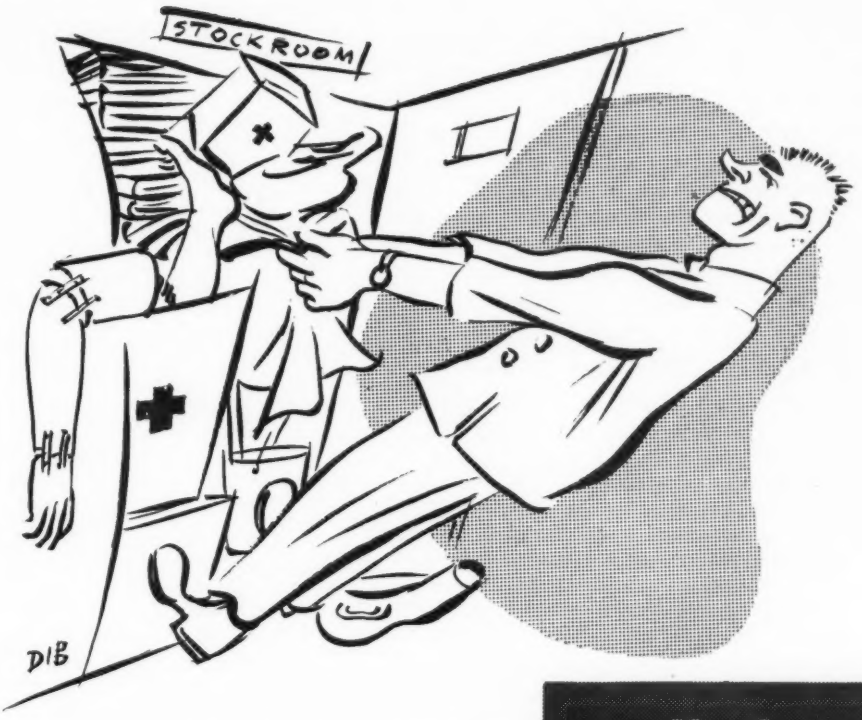
be an active leader in community health, the member of the auxiliary must be an informed member and have knowledge of both the needs of her community and what she can do about it.

Past years have shown that in the Florida Auxiliary we work together and that the tremendous accomplishments we have had, have been realized by the participation of practically every member of every component auxiliary with her local auxiliary and the participation of every component auxiliary in every program of the state and national auxiliary.

State reports come out of the compiled material and reports sent from the component auxiliaries and the record of working together in Florida is easily proved by the number of awards, examples from Florida and other mentions that are given us in increasing number at each national convention. If we try to analyze why we have been so successful in Florida in working together and accomplishing the goals we have set, we believe it could be boiled down to one thing — the realization on the part of the state auxiliary that people learn from each other. An opportunity to learn from each other is given whenever the personnel of the component auxiliaries get together. The informality of our meetings, we believe, lends itself to even the most timid soul having no fear of asking questions and the answers coming not from one person who says it all, but rather from an exchange of experiences between those of one group and those of another. Add to the tolerant and understanding friendship that develops between the various individuals of the various component auxiliaries, that there is never a feeling of anyone taking from another but rather a delight that someone felt what had been done was so well worthwhile that another group wanted to use it, and you have the recipe for our working together and for the success of the Florida Auxiliary.

With the realization that Florida component auxiliaries are from our largest to almost our smallest county and that our component auxiliaries vary in size from 386 members (Dade) to 11 members (Jackson-Calhoun) that one gets the vision of what happens when our whole state is covered, and from all the members of Dade to all the members of Jackson-Calhoun, everyone realizes that the biggest auxiliary doesn't always





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do the best job and that the smallest auxiliary is just as important and many times is more important than the largest. It is with the tolerance and understanding of each other's problems and the give and take of experiences that we work so well together. Yes, the members of the Florida Auxiliary, have learned that every locality is important and that the largest group may often learn from the smallest and vice versa.

If the legislature in Florida worked as well together as do the component auxiliaries, that legislature would, indeed, become a paradise.

Mrs. Richard F. Stover

The annual workshop meetings of the Woman's Auxiliary to the Florida Medical Association are being held October 10, 11, 12 and 14 in connection with the Medical District Meetings of the Association.

(Continued from page 330)

Young, Elbert Lewis, St. Petersburg (Tennessee 1953)
Young, Lloyd Ulin, Cleveland (Virginia 1952)
Young, William Arthur, Natick, Mass. (Toronto 1936)

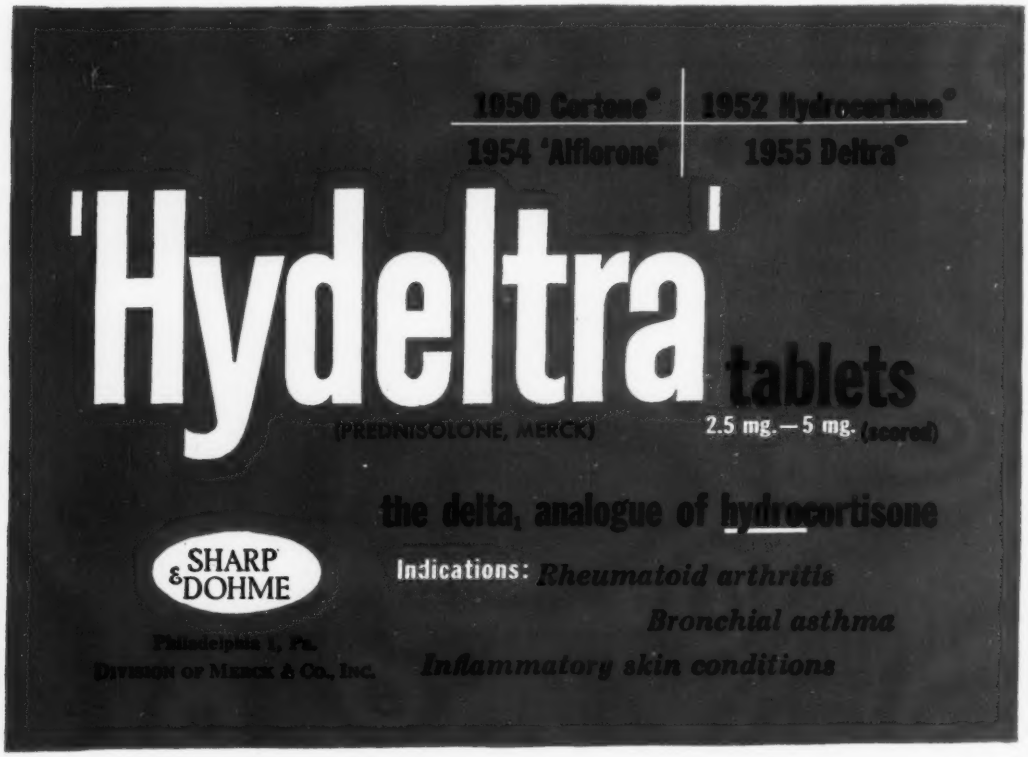
Zelnick, Saul, Brooklyn (New York 1954)

BOOKS RECEIVED

Recent Advances in Medicine and Surgery (19-30 April 1954) Based on Professional Medical Experiences in Japan and Korea 1950-1953. Vol. I, pp. 530. Vol. II, pp. 421. Price, $1.75. Washington 25, D. C.

Listed as Medical Science Publication No. 4, these volumes represent complete notes of a course entitled Recent Advances in Medicine and Surgery conducted by the Army Medical Service Graduate School, Walter Reed Army Medical Center, Washington, D. C., April 19 to 30, 1954. The title, as stated in the preface, is a slight misnomer inasmuch as it was intended by those responsible for the course's design that it reflect primarily the professional experiences, problems encountered and lessons learned by the Army Medical Service during the Korean war. To this end the faculty was selected from persons "who were there," who met and successfully coped with the actual problems and, as a result, could speak with the authority of personal and intimate knowledge of the subject. The student body was drawn from mature clinicians so that a critical discussion of papers could be had prior to final editing for publication. The opinions collected are considered to represent the best thinking on the subject at this time and, in a literal sense, constitute a history of the professional and clinical activities of the Army Medical Service in Korea.

It is hoped that the timely publication of these lessons and their general distribution to Reserve training groups, libraries and medical schools, will help to give better preparation to the next doctors who are called on to treat mass casualties — whether they be as a result of military or civilian disasters.



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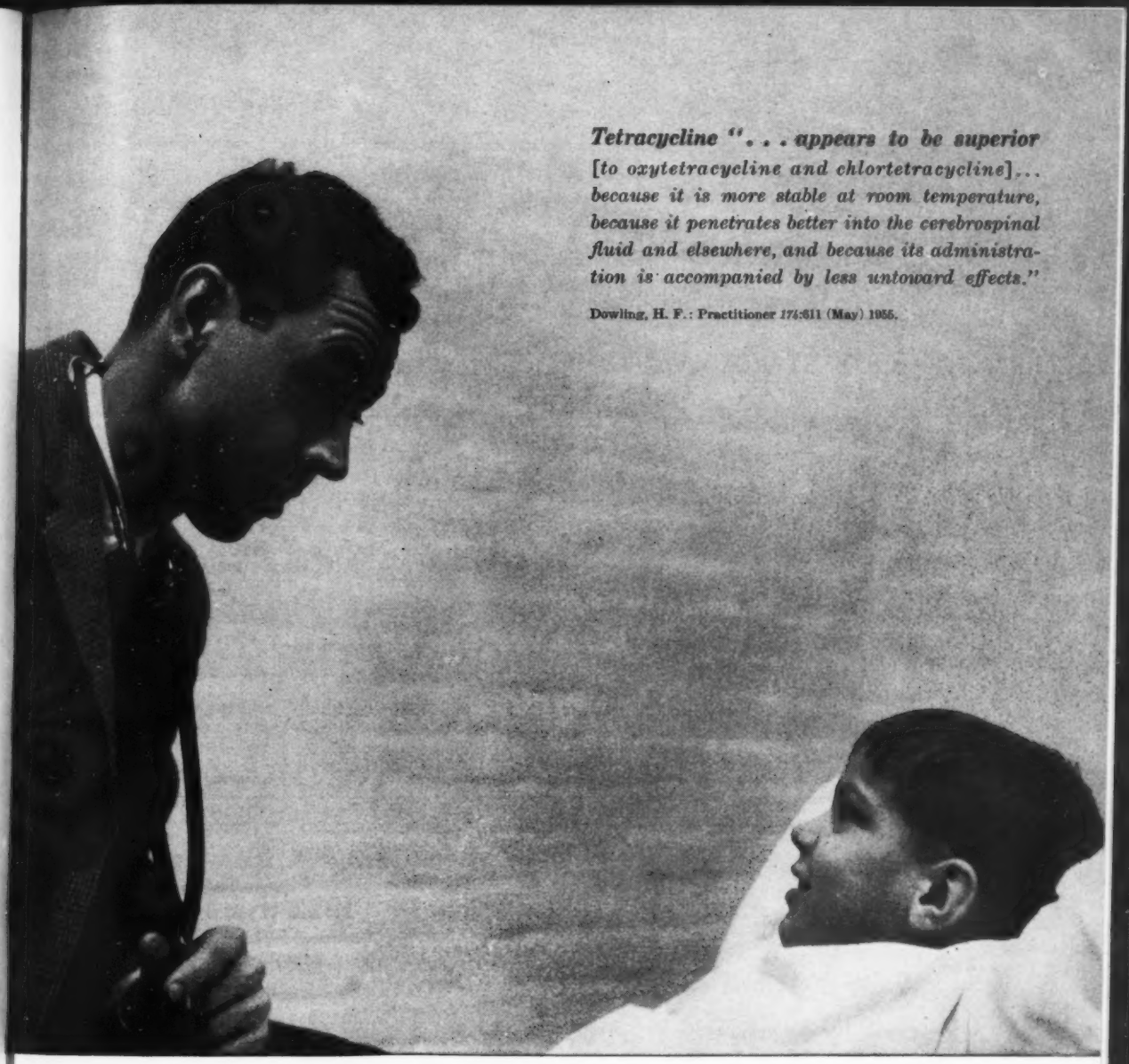

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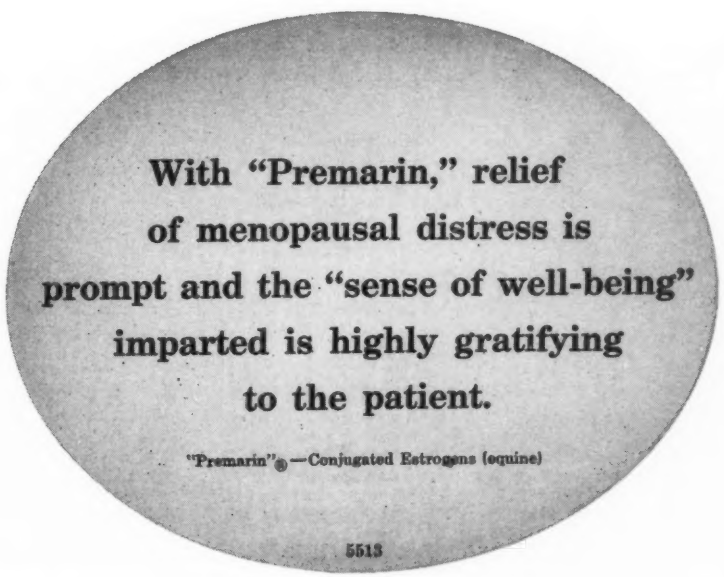

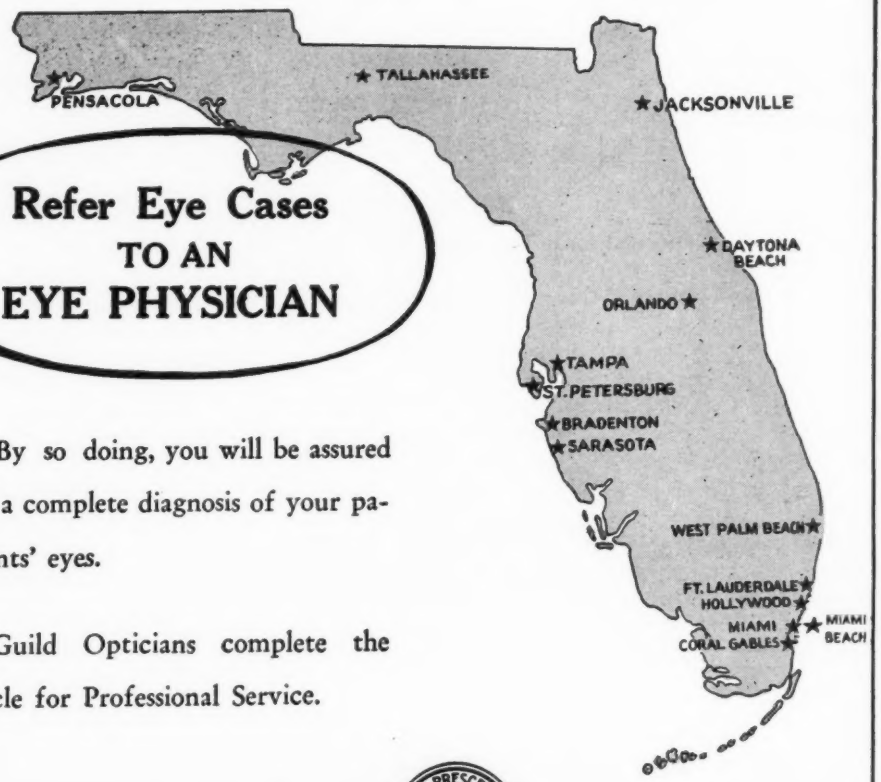

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West Palm Beach	H. T. Sait	320 Datura St.
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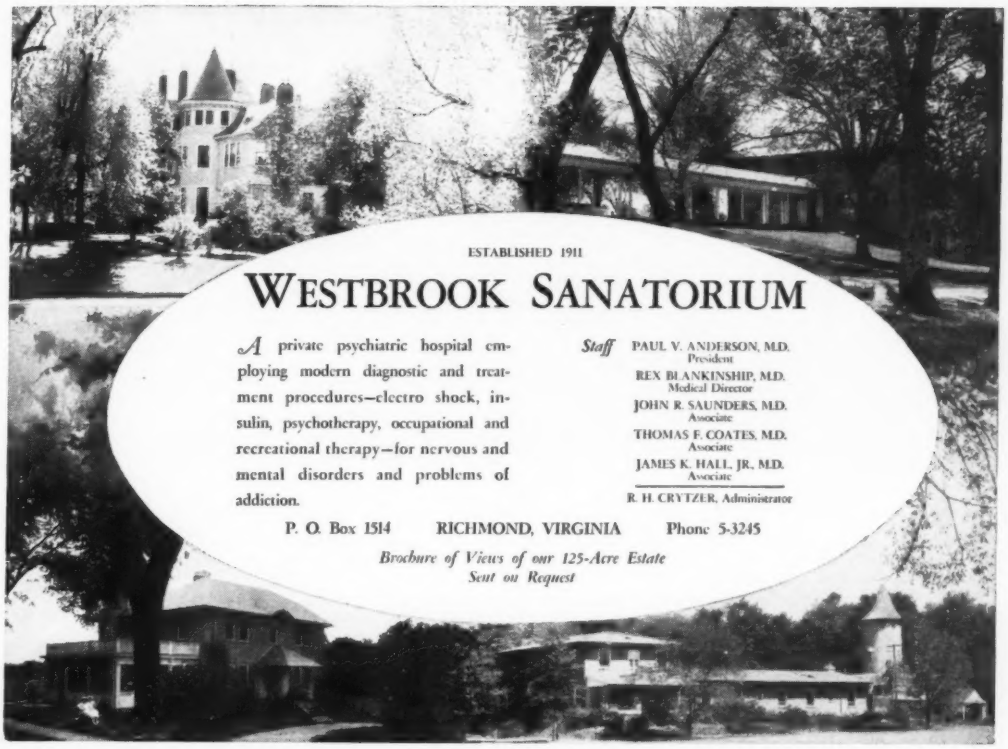

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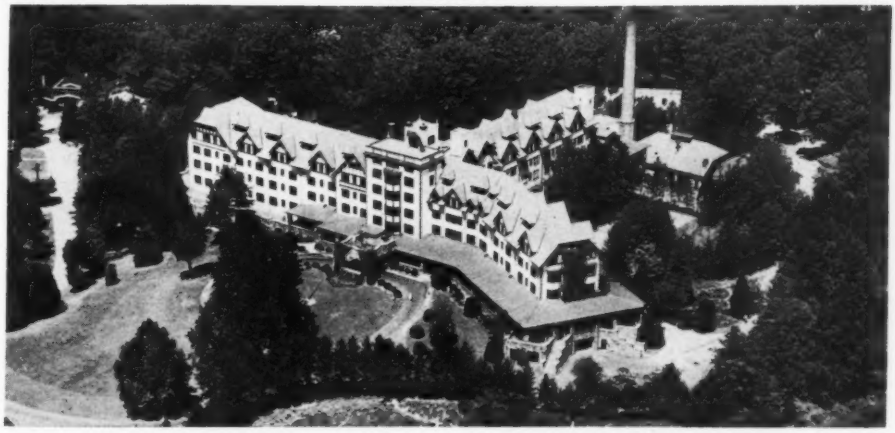

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ORGANIZATION	PRESIDENT	SECRETARY	ANNUAL MEETING
Florida Medical Association	John D. Milton, Miami	Samuel M. Day, Jacksonville	Miami Beach, May 13-16, '56
Florida Medical Districts	Ralph W. Jack, Miami	Council Chairman	
A-Northwest	William P. Hixon, Pensacola	Walter J. Baker, Foley	Pensacola, Oct. 14, '55
B-Northeast	Henry J. Babers Jr., Gainesville	Charles L. Park Sr., Sanford	Gainesville, Oct. 12, '55
C-Southwest	C. Frank Chunn, Tampa	James R. Boulware Jr., Lakeland	Lakeland, Oct. 11, '55
D-Southeast	James R. Sory, West Palm Beach	Ralph S. Sappenfield, Miami	Fort Lauderdale, Oct. 10, '55
Florida Specialty Societies			
Academy of General Practice	Frank T. Linz, Tampa	James B. Hodge Jr., Tampa	Daytona Beach, Oct. 22-23, '55
Allergy Society	W. Ambrose McGee, W. P. Bch.	Norris M. Beasley, Ft. Lauderdale	Miami Beach, May, '56
Anesthesiologists, Soc. of	Wayland T. Coppedge Jr., Jax	William H. Houston, Jacksonville	" " " "
Chest Phys., Am. Coll., Fla. Chap.	Hawley H. Seiler, Tampa	William L. Potts, Lantana	" " " "
Derm. and Syph., Assn. of	Joseph L. Hundley, Orlando	Kenneth J. Weiler, St. Petersburg	" " " "
Health Officers' Society	Clarence L. Brumback, W. P. Bch.	Lorenzo L. Parks, Jacksonville	" " " "
Industrial and Railway Surgeons	Frank L. Fort, Jacksonville	John H. Mitchell, Jacksonville	" " " "
Neurology & Psychiatry	Edward H. Williams, Miami	J. Robert Campbell, Tampa	" " " "
Ob. and Gynec. Society	J. Champneys Taylor, J'sonville	Reuben B. Chrisman Jr., Miami	Daytona Beach, Oct. 22-23, '55
Ophthal. & Otol., Soc. of	Charles W. Boyd, Jacksonville	Kenneth S. Whitmer, Miami	" " " "
Orthopedic Society	Edward W. Cullipher, Miami	Robert P. Keiser, Coral Gables	" " " "
Pathologists, Society of	Millard B. White, Sarasota	Wray D. Storey, Tampa	" " " "
Pediatric Society	Lewis T. Corum, Tampa	Joel V. McCall Jr., Daytona Beach	Ft. Lauderdale, Nov. 3-5, '55
Proctologic Society	Thomas F. Nelson, Tampa	George Williams Jr., Miami	Miami Beach, May, '56
Radiological Society	Hugh G. Reaves, Sarasota	Donald H. Gahagen, Ft. Lauderdale	Daytona Beach, Oct. 22-23 '55
Surgeons, Am. Coll., Fla. Chapter	Joseph S. Stewart, Miami	C. Frank Chunn, Tampa	" " " "
Urological Society	David W. Goddard, Daytona Bch.	W. Dotson Wells, Fort Lauderdale	" " " "
Florida—			
Basic Science Exam. Board	Mr. Paul A. Vestal, Winter Park	M. W. Emmel, D.V.M., Gainesville	Gainesville, Nov. 5, '55
Blood Banks, Association	Louis E. Pohlman, Orlando	Mrs. Estelle Lieberman, W. P. Bch.	
Blue Cross of Florida, Inc.	Mr. C. Dewitt Miller, Orlando	Mr. H. A. Schroder, Jacksonville	St. Petersburg, Dec. 6, '55
Blue Shield of Florida, Inc.	Russell B. Carson, Ft. Lauderdale	John T. Stage, Jacksonville	
Cancer Council	Ashbel C. Williams, Jacksonville	Lorenzo L. Parks, Jacksonville	Miami Beach, May 13, '56
Clinical Diabetes Assn.	Sidney Davidson, Lake Worth	Edward R. Smith, Jacksonville	Daytona Beach, Oct. 20-21, '55
Dental Society, State	T. A. Price, D.D.S., Miami	W. A. Buhner, D.D.S., Daytona Bch.	Miami Beach, May 28-30 '56
Heart Association	Victor H. Kugel, Miami Beach	Edwin P. Preston, Miami	
Hospital Association	Mr. Pat N. Groner, Pensacola	Mr. Steve F. McCrimmon, C. Gbls.	St. Petersburg, Dec. 8-9, '55
Medical Examining Board	Morris B. Seltzer, Daytona Bch.	Homer L. Pearson Jr., Miami	Miami Beach, Nov. 20-22, '55
Medical Postgraduate Course	Turner Z. Cason, Jacksonville	Chairman	
Nurse Anesthetists, Fla. Assn.	Miss Dorothy Jackson, C. Gables	Mrs. Lulla F. Bryan, Miami	St. Petersburg, Dec. 6-8, '55
Nurses Association, State	Martha Wolfe R.N., Coral Gables	Agnes Anderson, R.N., Orlando	Daytona Beach, Nov. 28-30, '55
Pharmaceutical Assoc., State	Miss Frances Walpole, Sarasota	Mr. R. Q. Richards, Ft. Myers	
Public Health Association	Mr. J. A. Mulrennan, Jacksonville	Mr. Fred B. Ragland, Jacksonville	Daytona Beach, Oct. 20-22, '55
Trudeau Society	Harold W. Johnston, Orlando	Howard M. DuBose, Lakeland	
Tuberculosis & Health Assn.	Judge Ernest E. Mason, Pensacola	Mr. Ernest L. Abel, W. Palm Beach	
Woman's Auxiliary	Mrs. Samuel Lombardo, J'sonville	Mrs. Leffie M. Carlton Jr., Tampa	Miami Beach, May 13-16, '56
American Medical Association	Elmer Hess, Erie, Pa.	Geo. F. Lull, Chicago	Chicago, June 11-15, '56
A.M.A. Clinical Session	Elmer Hess, Erie, Pa.	Geo. F. Lull, Chicago	Boston, Nov. 29-Dec. 2, '55
Southern Medical Association	Robt. L. Sanders, Memphis, Tenn.	Mr. V. O. Foster, Birmingham	Houston, Nov. 14-17, '55
Alabama Medical Association	F. L. Chenault, Decatur	Douglas L. Cannon, Montgomery	Birmingham, Apr. 19-21, '56
Georgia, Medical Assn. of	H. Dawson Allen Jr., Milledgeville	David Henry Poer, Atlanta	Atlanta, May 13-16, '56
M. E. Hospital Conference	Mr. D. O. McClusky Jr. Tuscaloosa, Ala.	Mr. Pat Groner, Pensacola	Miami Beach, Apr. 18-20, '56
Southeastern Allergy Assn.	Ben Miller, Columbia, S. C.	Kath. B. MacInnis, Columbia, S.C.	Charlotte, N. C., Oct. '56
Southeastern, Am. Urological Assn.	Sidney Smith, Raleigh, N. C.	Robert F. Sharp, New Orleans	Hollywood, Mar. 25-29, '56
Southeastern Surgical Congress	Donald S. Daniel, Richmond	B. T. Beasley, Atlanta	Richmond, Mar. 12-15, '56
Gulf Coast Clinical Society	Walter C. Payne Sr., Pensacola	Barkley Beidleman, Pensacola	Pensacola, Oct. 27-28, '55

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SOCIETY	PRESIDENT	SECRETARY	Meeting Date	Total Members
Alachua	Edwin H. Andrews, Gainesville	Henry S. Blank, Gainesville	2nd Tues.	55
***Bradford, Gilchrist, Union**				
Bay	William F. Humphreys Jr., Panama City	Roderick C. Webb, Panama City	1st Tues.	28
Brevard	Lee Rogers Jr., Cocoa	Charles E. Russell, Cocoa	2nd Tues.	37
Broward	Ernest E. Serrano, Hollywood	Alfred E. Cronkite, Fort Lauderdale	4th Tues.	121
Columbia	Robert B. Harkness, Lake City	Thomas H. Bates, Lake City	1st Mon.	11
***Baker**				
Dade	L. Washington Dowlen, Miami	Robert F. Dickey, Miami	1st Tues	725
DeSoto-Hardee-Highlands-Glades	Gordon H. McSwain, Arcadia	Harold S. Agnew, Arcadia	1st Tues.	28
Duval	Raymond H. King, Jacksonville	Eugene M. Frame, Jacksonville	1st Tues.	300
***Clay**				
Escambia	George W. Morse, Pensacola	Paul F. Baranco, Pensacola	2nd Tues.	107
***Santa Rosa**				
Franklin-Gulf	Warren T. Weathington, Apalachicola	Joseph P. Hendrix, Port St. Joe	Last Wed.	6
Hillsborough	Frank S. Adamo, Tampa	Julien C. Pate Jr., Tampa	1st Tues.	192
Indian River	Kip G. Kelso, Vero Beach	Vernon L. Fromang, Vero Beach	2nd Tues.	9
Jackson-Calhoun	Henry I. Langston, Marianna	Francis M. Watson, Marianna	Quarterly	17
Lake	Louis R. Bowen, Eustis	J. Basil Hall, Tavares	1st Wed.	29
***Sumter**				
Lee-Charlotte-Collier-Hendry	Baker Whisnant, Fort Myers	James L. Bradley, Fort Myers	3rd Mon.	38
Leon-Gadsden-Liberty-Wakulla-Jefferson	William L. Hunter, Monticello	Odis G. Kendrick Jr., Tallahassee	Quarterly	66
Madison	A. Franklin Harrison, Madison	Wallace E. Winter, Madison		8
Manatee	Marjorie L. Warner, Bradenton	Harvey C. Pauley Jr., Bradenton	2nd Tues.	31
Marion	William H. Turnley, Ocala	Bertrand F. Drake, Dunnellon	3rd Tues.	31
***Levy**				
Monroe	Ralph Herz, Key West	William R. Ploss, Key West	1st Thurs.	15
Nassau	David G. Humphreys, Fernandina Beach	John W. McClane, Fernandina Beach	Last Fri.	11
Orange	Don C. Robertson, Orlando	Walter A. Derrick, Orlando	3rd Wed.	192
***Osceola**				
Palm Beach	Edwin W. Brown, West Palm Beach	James R. Anderson, West Palm Beach	4th Mon.	143
Pasco-Hernando-Citrus	Harry G. Brownlee, Zephyrhills	W. Wardlaw Jones, Dade City	2nd Thurs.	17
Pinellas	Clyde O. Anderson, St. Petersburg	Whitman C. McConnell, St. Petersburg	1st Mon.	227
Polk	Samuel J. Clark, Lakeland	Marion W. Hester, Lakeland	2nd Wed.	101
Putnam	Grover C. Collins, Palatka	Alfred P. Peretti, Palatka	2nd Tues.	10
St. Johns	George C. Hopkins, St. Augustine	Reuben J. Plant Jr., St. Augustine	3rd Tues.	21
St. Lucie-Okeechobee-Martin	Henry E. Branca, Fort Pierce	Adrian M. Sample, Fort Pierce	3rd Thurs.	24
Sarasota	Melvin M. Simmons, Sarasota	Andrew J. Jesacher, Sarasota	2nd Tues.	58
Seminole	John M. Morgan, Sanford	Terry Bird, Sanford	2nd Tues.	20
Suwannee	William P. Blackmon, Jasper	Hiram B. Curry, Jasper	1st Sat.	11
***Hamilton, Lafayette**				
Taylor	John H. Parker Jr., Perry	Ralph J. Greene, Perry	Last Fri.	5
***Dixie**				
Volusia	Robert L. Miller, Daytona Beach	Achille A. Monaco, Daytona Beach	2nd Tues.	84
***Flagler**				
Walton-Okaloosa	Richard H. Lee, Crestview	Frederic E. Caldwell, Fort Walton Beach	3rd Tues	20
Washington-Holmes	L. H. Paul, Bonifay	Bayllye W. Dalton, Chipley		5
			Total	2,803

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VOLUME XLIII
NUMBER 4

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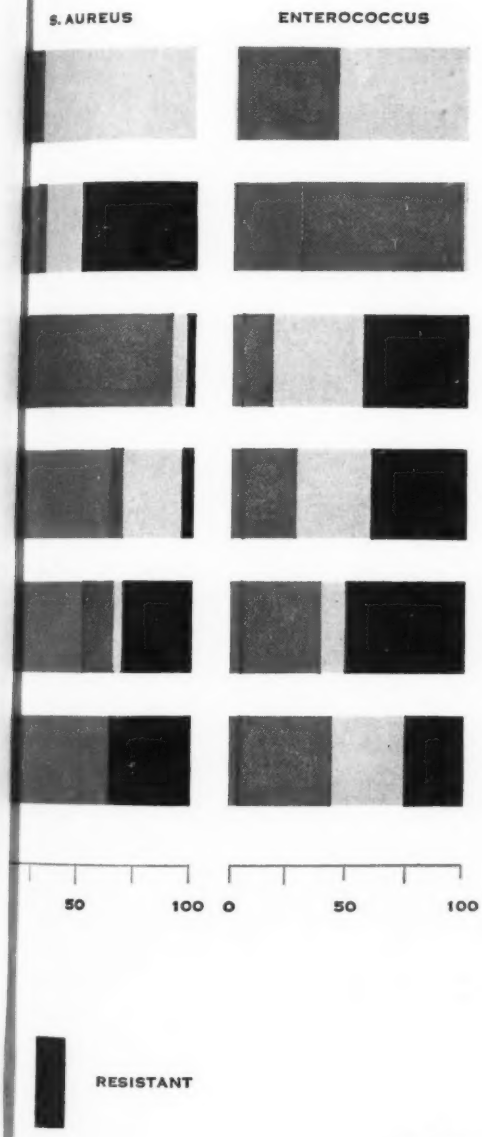

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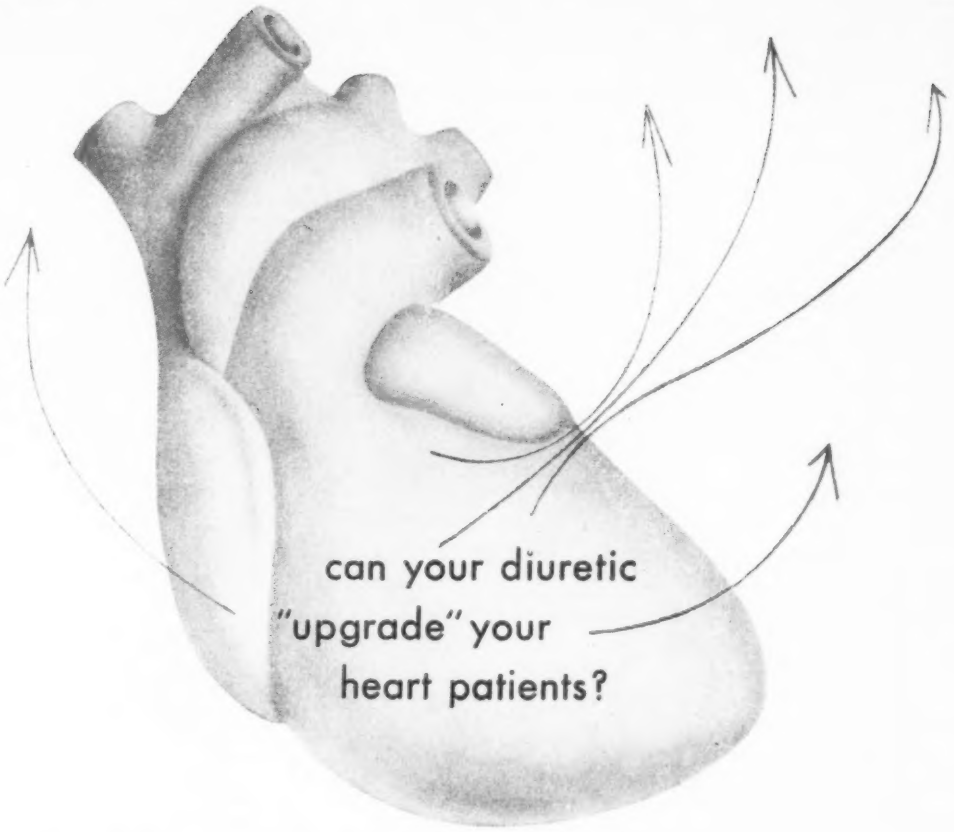

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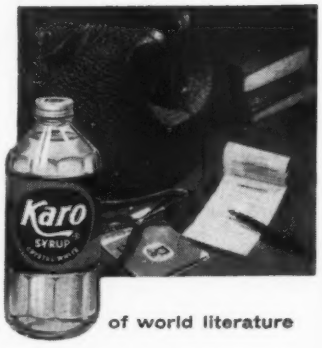

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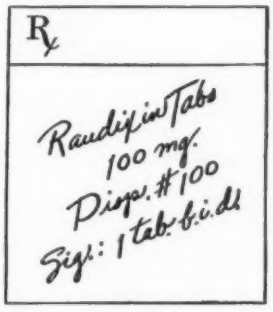

*Ataractic, from ataraxia: calmness untroubled by mental or emotional excitation. (Use of term suggested by Dr. Howard Fabing at a recent meeting of the American Psychiatric Association.)

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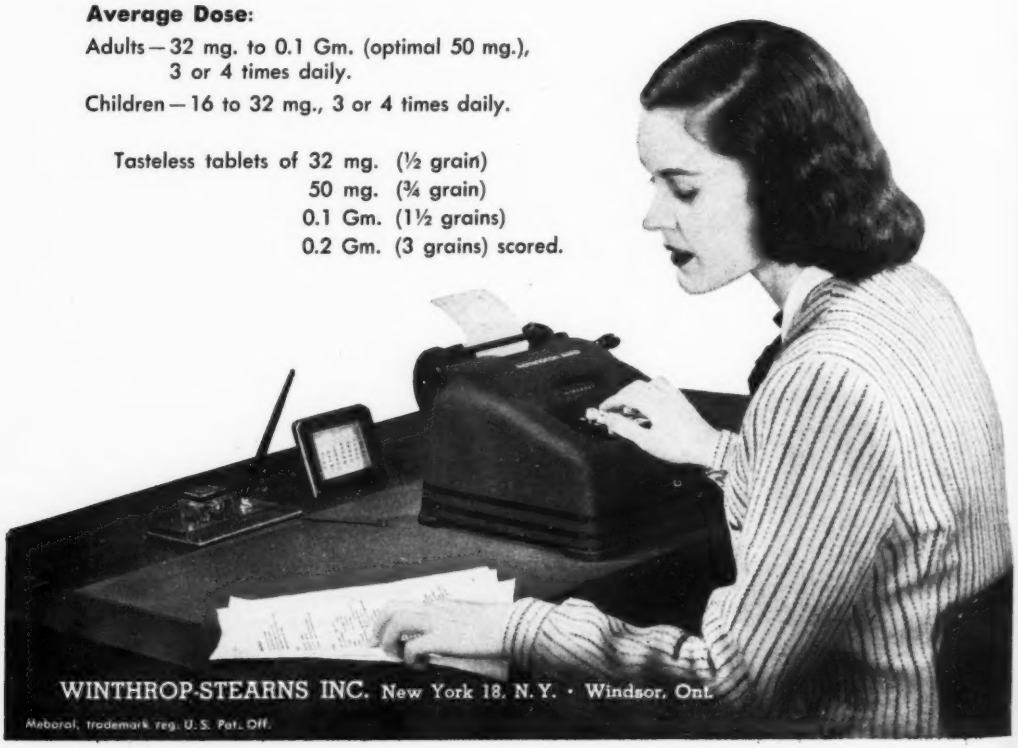

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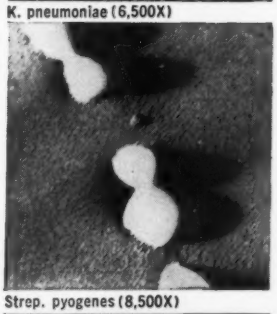
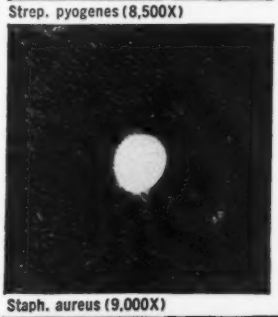


Strep. pyogenes (8,500X)



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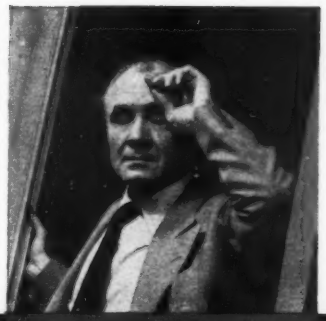

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(1) Payne, R. W.; Shetlar, M. R.; Farr, C. H.; Hellbaum, A. A., and Ishmael, W. K.: J. Lab. & Clin. Med. *45*:331, 1955. (2) Bunim, J. J.; Williams, R. R., and Black, R. L.: J. Chron. Dis. *1*:168, 1955. (3) Holbrook, W. P.: M. Clin. North America *39*:405, 1955.

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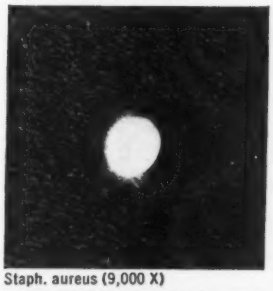
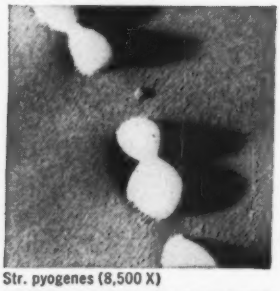


Staph. aureus (9,000 X)



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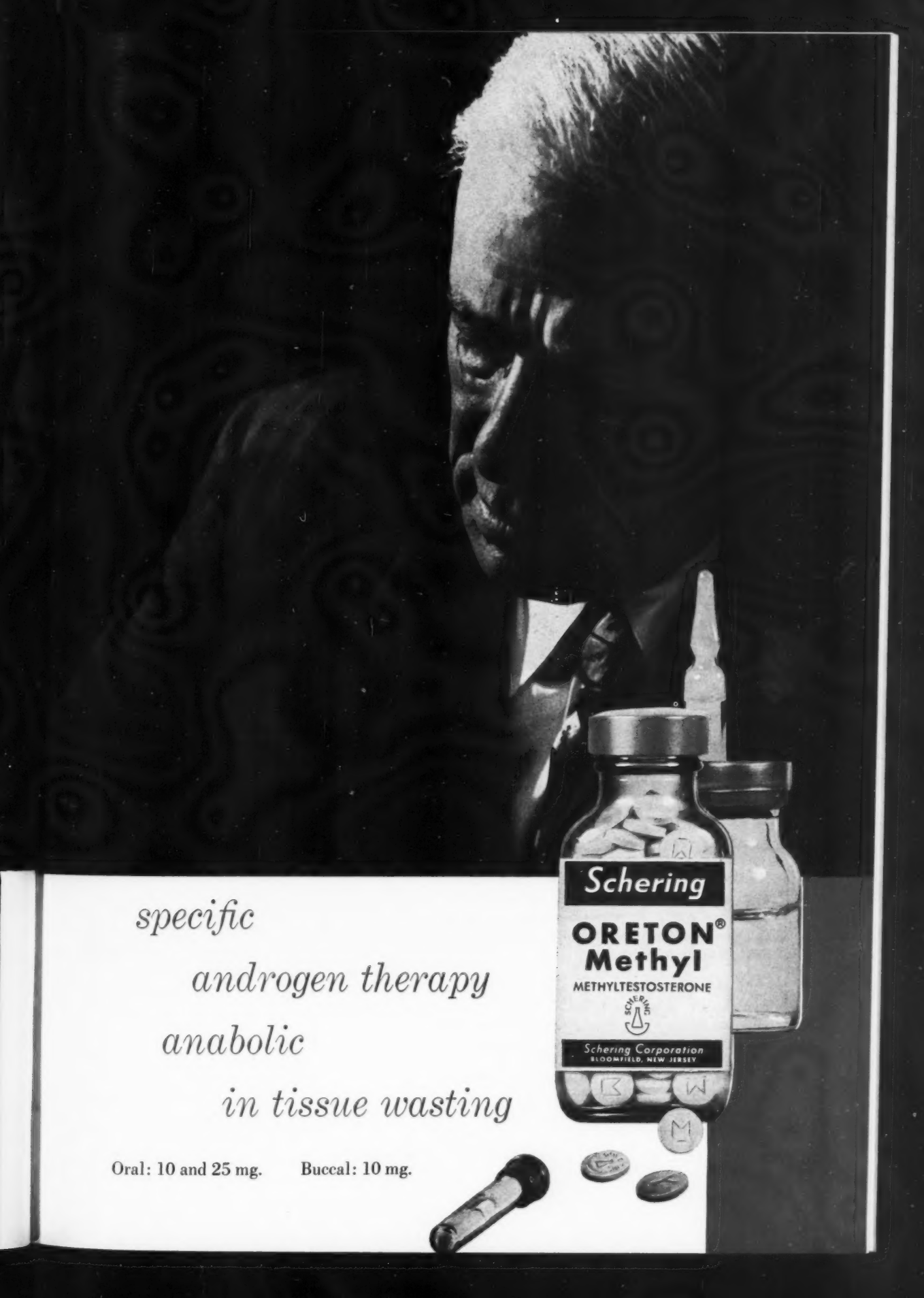

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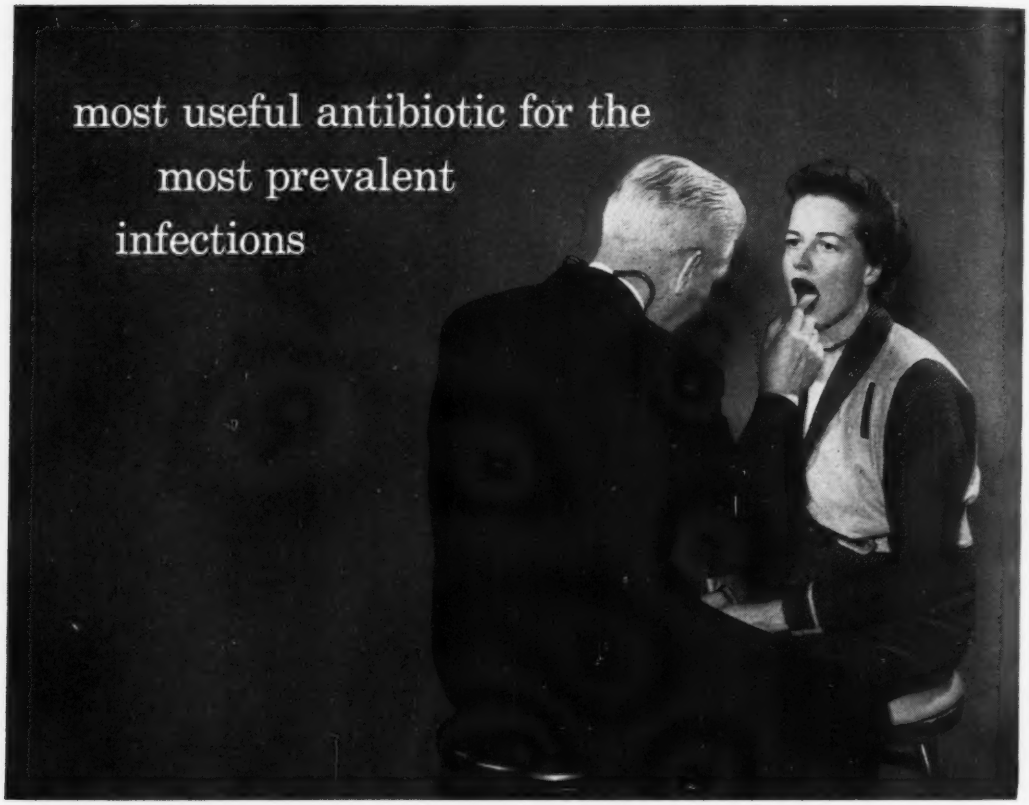

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